

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH

4566

County

Balt

Fowlesburg

Village or City

Fowlesburg

(No.)

St.; Ward

Registration Dist. No. 38

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME

Elmer Abbott

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

male

4 COLOR OR RACE

white

5 SINGLE,

MARRIED,
WIDOWED,
SEPARATED
(Write the word)

single

6 DATE OF BIRTH

5 4 1914
(Month) (Day) (Year)

7 AGE

— yrs. — mos. 5 ds. OR LESS than 1 day, hrs. OR min. ?

8 OCCUPATION

(a) Trade, profession, or particular kind of work

home

(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE
(State or country)

Md

PARENTS

10 NAME OF FATHER

Jas. M. Abbott

11 BIRTHPLACE OF FATHER
(State or country)

Md

12 MAIDEN NAME OF MOTHER

Sarah Hare

13 BIRTHPLACE OF MOTHER
(State or country)

Md

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

James M. Abbott

(Address)

Fowlesburg

15

Filed

May 5 1914 Jas. M. Wilson

REGISTRAR

STATE OF MARYLAND
CERTIFICATE OF DEATH

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

5 9 1914
(Month) (Day) (Year)

17

I HEREBY CERTIFY, That I attended deceased from

191 to 191
that I last saw h. alive on 191

and that death occurred on the date stated above, at 2 P. M.

The CAUSE OF DEATH* was as follows:

Convulsions

(Duration) yrs. mos. ds.

Contributory
(Secondary)

Intoxication

(Duration) yrs. mos. ds.

(Signed)

Jas. H. Wilson

M. D.

191 (Address) Fowlesburg Md

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Emory

May 5 1914

20 UNDERTAKER

ADDRESS

none - father Fowlesburg

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

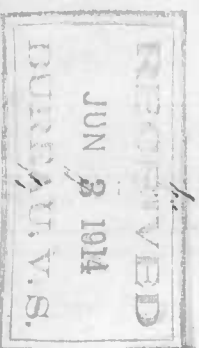
[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry; and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mining*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Former (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc. *Carcin-*

oma, *Sarcoma*, etc., of _____ (name origin; "Gartner" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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1 PLACE OF DEATH County <u>Balto</u>		4567	(151)	STATE OF MARYLAND CERTIFICATE OF DEATH	
Village or City <u>Groome</u>		(No. <u>Rodgers Linden</u> St.;	Registration Dist. No. <u>38</u>		[If death occurred in a hospital or institution, give its NAME instead of street and number.]
2 FULL NAME <u>Norman Luther - No name given</u> <u>Adkins</u>					
PERSONAL AND STATISTICAL PARTICULARS					
3 SEX <u>Male</u>	4 COLOR OR RACE <u>White</u>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word)			
6 DATE OF BIRTH <u>May 12 1914</u> (Month) (Day) (Year)					
7 AGE _____ yrs. _____ mos. _____ ds. OR LESS than 1 day, _____ hrs. _____ min. ?					
8 OCCUPATION (a) Trade, profession, or particular kind of work _____ (b) General nature of industry, business, or establishment in which employed (or employer) _____					
9 BIRTHPLACE (State or country) <u>Groome Balto Co Md</u>					
PARENTS	10 NAME OF FATHER <u>Merle Adkins</u>				
	11 BIRTHPLACE OF FATHER (State or country) <u>Wisconsin</u>				
	12 MAIDEN NAME OF MOTHER <u>Hannah Douglas</u>				
	13 BIRTHPLACE OF MOTHER (State or country) <u>Baltimore Md</u>				
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>Dr. M. Hocking</u> (Address) <u>Groome Md</u>					
15 FILED <u>May 13 1914</u> <u>M. E. Parker</u> <u>Deputy Local</u> REGISTRAR					
MEDICAL CERTIFICATE OF DEATH					
16 DATE OF DEATH <u>May 13 1914</u> (Month) (Day) (Year)					
17 I HEREBY CERTIFY, That I attended deceased from <u>May 12 1914</u> to _____, 191____, that I last saw him alive on <u>May 12 1914</u> , and that death occurred on the date stated above, at <u>1. a</u> m. The CAUSE OF DEATH* was as follows: <u>Birth.</u> <u>Norman</u> (Duration) _____ yrs. _____ mos. _____ ds. Contributory _____ Secondary _____ (Signed) <u>Dr. M. Hocking</u> , M. D. <u>May 14 1914</u> (Address) <u>Groome Md</u> State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, OR HOMICIDAL. 18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS) At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds. Where was disease contracted, If not at place of death? _____ Former or usual residence _____ 19 PLACE OF BURIAL OR REMOVAL <u>To John Chapkins Mead School</u> DATE OF BURIAL <u>May 13 1914</u> 20 UNDERTAKER ADDRESS _____					

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

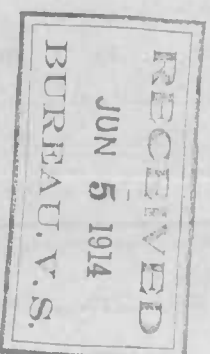
[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The statement worked on may form part of the second material. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not faithfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcin-*

oma, Sarcoma, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asphyxia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Confeatal," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Reverber wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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1 PLACE OF DEATH

4568

County BaltimoreVillage or City St. Agnes Hospital (No. _____)

St.; _____ Ward)

STATE OF MARYLAND
CERTIFICATE OF DEATHRegistration Dist. No. 42

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME

Charles A. Albright

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) Single

6 DATE OF BIRTH Nov. 11, 1896
(Month) (Day) (Year)

7 AGE 17 yrs. 5 mos. 26 ds. If LESS than 1 day, _____ hrs. OR _____ min. ?

8 OCCUPATION
(a) Trade, profession, or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE (State or country) Baltimore, Co

10 NAME OF FATHER Albert F. Albright

11 BIRTHPLACE OF FATHER (State or country) Maryland

12 MAIDEN NAME OF MOTHER Laura Platt

13 BIRTHPLACE OF MOTHER (State or country) Maryland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mr. Albert Albright(Address) Abolton Howard Co

15 Filed May 8, 1914 St. Agnes Hospital
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH May 7, 1914
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from April 26, 1914, to May 7, 1914, that I last saw him alive on May 7, 1914

and that death occurred on the date stated above, at 5 p. m.

The CAUSE OF DEATH* was as follows:

Typhoid Fever(Duration) — yrs. — mos. 15 ds.Contributory Typhoid & Acute
Secondary dehilation of Stomach

(Duration) ? yrs. — mos. — ds.

(Signed) Walter G. Colquhoun, M. D.May 7, 1914 (Address) St. Agnes Hospital

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18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death _____ yrs. _____ mos. 11 ds. in the State _____ yrs. _____ mos. _____ ds.

Where was disease contracted, If not at place of death?

Former or usual residence Abolton Howard Co.19 PLACE OF BURIAL OR REMOVAL St. Paul Cem. Grant to Me DATE OF BURIAL May 10, 191420 UNDERTAKER Wm. J. Tucker & Son ADDRESS Carmelina Pica

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

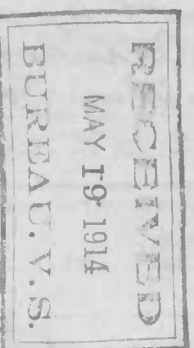
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oma, Sarcoma, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Con-fusional," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæ-mia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—acci-dent; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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1 PLACE OF DEATH County <u>Baltimore</u> 4569		STATE OF MARYLAND CERTIFICATE OF DEATH	
Village or City <u>Towson</u> (No. <u>5</u> , <u>Jefferson</u> St.; <u>Ward</u>)		Registration Dist. No. <u>88</u>	
2 FULL NAME <u>Margaret Alb</u>			
PERSONAL AND STATISTICAL PARTICULARS			
3 SEX <u>Female</u>	4 COLOR OR RACE <u>White</u>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) <u>widow</u>	
6 DATE OF BIRTH <u>October 29th</u> , 1 <u>1914</u> (Month) (Day) (Year)			
7 AGE <u>80</u> yrs. <u>5</u> mos. <u>25</u> ds.		It LESS than 1 day, <u>hrs.</u> OR min. ?	
8 OCCUPATION (a) Trade, profession, or particular kind of work <u>None</u> (b) General nature of industry, business, or establishment in which employed (or employer) <u>None</u>			
9 BIRTHPLACE (State or country) <u>Germany</u>			
PARENTS	10 NAME OF FATHER <u>John M. Gaylor</u>		
	11 BIRTHPLACE OF FATHER (State or country) <u>Not known</u>		
	12 MAIDEN NAME OF MOTHER <u>Margaret Gaylor</u>		
13 BIRTHPLACE OF MOTHER (State or country) <u>Not known</u>			
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>Harry S. Alb</u> (Address) <u>Towson, Md</u>			
15 Filed <u>5/23</u> , 191 <u>4</u> <u>Clara Smith</u> REGISTRAR		MEDICAL CERTIFICATE OF DEATH	
		16 DATE OF DEATH <u>May 22</u> , 191 <u>4</u> (Month) (Day) (Year)	
		17 I HEREBY CERTIFY, That I attended deceased from <u>May 5th</u> , 191 <u>4</u> , to <u>May 22</u> , 191 <u>4</u> that I last saw her alive on <u>May 22</u> , 191 <u>4</u> and that death occurred on the date stated above, at <u>2 p.</u> m. The CAUSE OF DEATH* was as follows: <u>Senility (Arteriosclerosis)</u>	
		(Duration) <u> </u> yrs. <u> </u> mos. <u> </u> ds.	
		Contributory (Secondary) <u> </u> (Duration) <u> </u> yrs. <u> </u> mos. <u> </u> ds.	
		(Signed) <u>W. A. Jarrett</u> , M. D. <u>May 23</u> 191 <u>4</u> (Address) <u>Towson, Md</u>	
*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.			
18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS) At place of death <u> </u> yrs. <u> </u> mos. <u> </u> ds. In the State <u> </u> yrs. <u> </u> mos. <u> </u> ds. Where was disease contracted, if not at place of death? Former or usual residence <u> </u>			
19 PLACE OF BURIAL OR REMOVAL <u>Lorona Presb Cemetery</u>		DATE OF BURIAL <u>May 24</u> , 191 <u>4</u>	
20 UNDERTAKER <u>John Burns Sons</u>		ADDRESS <u>Towson</u>	

If more blanks are needed, address State Registrar, 6 E Franklin St., Balto., Requesting V. S. No. 1.

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[Approved by U. S. Census and American Public Health Association.]

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Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Group"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc.. *Carcinoma*, *Sarcoma*, etc., of ----- (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary). 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congential," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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RECEIVED

JUN 5 1914

BUREAU U. V. S.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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1 PLACE OF DEATH		4570	STATE OF MARYLAND	
County <u>Baltimore</u>			CERTIFICATE OF DEATH	
Village or City <u>Crofton</u>		(No. _____)	St. _____	Ward _____
2 FULL NAME <u>Margaret P. Barnett</u>		Registered No. <u>38</u>		
[If death occurred in a hospital or institution, give its NAME instead of street and number.]				
PERSONAL AND STATISTICAL PARTICULARS			MEDICAL CERTIFICATE OF DEATH	
3 SEX <u>Female</u>	4 COLOR OR RACE <u>White</u>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) <u>Married</u>	16 DATE OF DEATH <u>May 29, 1914</u> (Month) (Day) (Year)	
6 DATE OF BIRTH <u>August 16, 1833</u> (Month) (Day) (Year)			17 I HEREBY CERTIFY That I attended deceased from <u>May 26, 1914, to May 29, 1914,</u> that I last saw her alive on <u>May 29, 1914,</u>	
7 AGE <u>Eighty</u> yrs. <u>9</u> mos. <u>13</u> ds. OR <u>1</u> day, <u>hrs.</u> OR <u>min.</u> ?			and that death occurred on the date stated above, at <u>1:30 a. m.</u> The CAUSE OF DEATH* was as follows: <u>Apoplexy</u>	
8 OCCUPATION (a) Trade, profession, or particular kind of work <u>Housewife</u> (b) General nature of industry, business, or establishment in which employed (or employer) <u>Housewife</u>			(Duration) _____ yrs. _____ mos. <u>3</u> ds.	
9 BIRTHPLACE (State or country) <u>Maryland</u>			Contributory (Secondary) <u>Arteriosclerosis</u> (Duration) <u>5</u> yrs. _____ mos. _____ ds.	
PARENTS	10 NAME OF FATHER <u>Joseph Branson</u>	(Signed) <u>J. Byrd Green</u> M. D. <u>May 29, 1914</u> (Address) <u>Crofton Md.</u>		
	11 BIRTHPLACE OF FATHER (State or country) <u>Baltimore Md.</u>	State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.		
	12 MAIDEN NAME OF MOTHER <u>Mary Duckshart</u>	18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS) At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds. Where was disease contracted, if not at place of death? Former or usual residence _____		
13 BIRTHPLACE OF MOTHER (State or country) <u>Baltimore Maryland</u>	19 PLACE OF BURIAL OR REMOVAL <u>Woodlawn Cem</u>			
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>Elizabeth Chapman</u> (Address) <u>Crofton Md.</u>			DATE OF BURIAL <u>June 1, 1914</u>	
15 Filed _____, 191 <u>June 1</u> <u>Clara Smith</u> REGISTRAR			20 UNDERTAKER <u>Wm. Cook</u>	
			ADDRESS <u>Balto. Md.</u>	

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

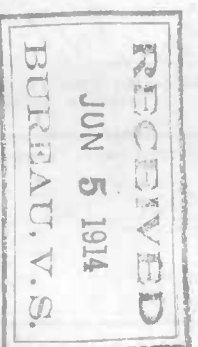
[Approved by U. S. Census and American Public Health Association.]

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Statement of cause of death.—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc. *Carcin-*

oma, *Sarcoma*, etc., of _____ (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Anæmia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "Puerperal septiciæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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1 PLACE OF DEATH 4571

County Baltimore

78

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No. 41Village or City Highlandtown 4705 Eastern Ave. (No. 4705) Ward 5th

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME George Barrett

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Single
(Write the word)

6 DATE OF BIRTH Sept 5, 1881
(Month) (Day) (Year)

7 AGE 33 yrs. 3 mos. 23 ds. If LESS than 1 day, hrs. OR min. ?

8 OCCUPATION
(a) Trade, profession, or particular kind of work Railroad En.
(b) General nature of industry, business, or establishment in which employed (or employer) Breakman

9 BIRTHPLACE (State or country) Prince Georges Md

10 NAME OF FATHER James W. Barrett

11 BIRTHPLACE OF FATHER (State or country) Prince Georges Md

12 MAIDEN NAME OF MOTHER Elizabeth Perkins

13 BIRTHPLACE OF MOTHER (State or country) Washington D.C.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Harry F. Keeler(Address) 4705 Eastern Ave

15 Filed May 28, 1914 W.E. McClanahan
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH May 27, 1914
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from May 23, 1914 to May 27, 1914.

that I last saw him alive on May 27, 1914

and that death occurred on the date stated above, at 8:20 a.m.

The CAUSE OF DEATH* was as follows:

Phthis Pulmonalis

About (Duration) 2 yrs. mos. ds.

Contributory Exhaustion

(Duration) 2 yrs. 3 mos. 8 ds.

(Signed) Thos. E. Egan, M. D.

May 28, 1914 (Address) 500 15th St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death 2 yrs. 3 mos. 8 ds. In the State 2 yrs. 3 mos. 8 ds.

Where was disease contracted? At Hospital Thos. Egan

If not at place of death? Thos. Egan

Former or usual residence. Phthis Pulmonalis

19 PLACE OF BURIAL OR REMOVAL Cathedral Cem.

DATE OF BURIAL May 30, 1914

20 UNDERTAKER W. G. Moran

ADDRESS Buick

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

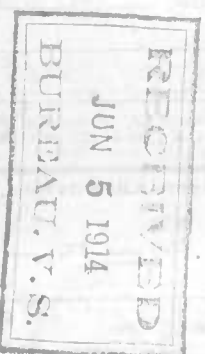
[Approved by U. S. Census and American Public Health Association.]

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1 PLACE OF DEATH

4572

County

Baltimore

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No. 40

Village or City

Rossview No.

St.; Ward)

[It death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME

Katharine Bayner

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White

5 SINGLE, MARRIED, WIDOWED, OR DIVORCED
(Write the word)

Married

6 DATE OF BIRTH

Nov

10

1888

(Month)

(Day)

(Year)

7 AGE

28

yrs.

7

mos.

+

ds.

OR LESS than 1 day, hrs. OR min. ?

8 OCCUPATION

(a) Trade, profession, or particular kind of work

Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE (State or country)

Maryland

10 NAME OF FATHER

Thomas Bayner

11 BIRTHPLACE OF FATHER (State or country)

Germany

12 MAIDEN NAME OF MOTHER

Katharine Smith

13 BIRTHPLACE OF MOTHER (State or country)

Germany

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Frank Bayner

(Address)

Rossview Md.

15

Filed

May 12, 1914

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

May

11

1914

(Month)

(Day)

(Year)

17

I HEREBY CERTIFY, That I attended deceased from

Apr 1

1914, to

May 11

1914

that I last saw him alive on

May 10

1914

and that death occurred on the date stated above, at 7 a. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(Duration) 2 yrs. 7 mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed)

C. H. H. H.

M. D.

May 11, 1914 (Address) Rossview

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place

of death

yrs.

mos.

ds.

In the

State

yrs.

mos.

ds.

Where was disease contracted,

If not at place of death?

Former or

usual residence.

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

St. Mary's Maple Rd

May 13, 1914

20 UNDERTAKER

ADDRESS

Hendell Lippel Son

330 S. Bond St.

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

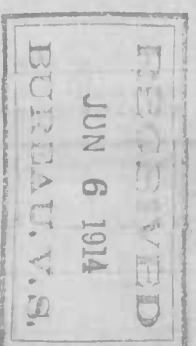
[Approved by U. S. Census and American Public Health Association.]

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1 PLACE OF DEATH Balto 4573 6 STATE OF MARYLAND
 County Balto 38 CERTIFICATE OF DEATH
 Village or City Melvale (No. Indus Ave for Melvale St.; Giles Ward)
 Registered No. 38
 [It death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME Dora Beale

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 SINGLE, Single
~~MARRIED~~
~~WIDOWED~~
~~DIVORCED~~
 (Write the word)

6 DATE OF BIRTH June 10, 1894
 (Month) (Day) (Year)

7 AGE 19 yrs. 11 mos. 6 ds. IT LESS than
 1 day.....hrs. OR.....min. ?

8 OCCUPATION
 (a) Trade, profession, or particular kind of work Machin Operator
 (b) General nature of industry, business, or establishment in which employed (or employer) Shaw Mfg Co

9 BIRTHPLACE (State or country) Balto Co Md

PARENTS
 10 NAME OF FATHER Unknown
 11 BIRTHPLACE OF FATHER (State or country) Unknown
 12 MAIDEN NAME OF MOTHER Unknown
 13 BIRTHPLACE OF MOTHER (State or country) Unknown

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
 (Informant) Florence Pennington
 (Address) Industrial Home Co. Giles Melvale, Md.

15 Filed May 18, 1914 M. J. Porter
deputy REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH May 16, 1914
 (Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from May 25, 1914, to May 16, 1914.

that I last saw him alive on May 14, 1914.

and that death occurred on the date stated above, at 10 P m.

The CAUSE OF DEATH* was as follows:

Acute Pulm Tuberculosis
by liver and K.P. infection
high temperature, undisch
tuberculosis (Duration) 6 yrs. 0 mos. 0 ds.

Contributory (Secondary) Mecelus Primary
liver 2 months (Duration) 2 yrs. 2 mos. 0 ds.

(Signed) W. W. Wines, M. D.
May 17, 1914. (Address) 1220 W. 1st St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)
 At place of death 0 yrs. 0 mos. 0 ds. In the State 0 yrs. 0 mos. 0 ds.

Where was disease contracted, It not at place of death?
 Former or usual residence.....

19 PLACE OF BURIAL OR REMOVAL Melvale Home DATE OF BURIAL May 19, 1914

20 UNDERTAKER H. S. Marshall ADDRESS 3539 Fall Road

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

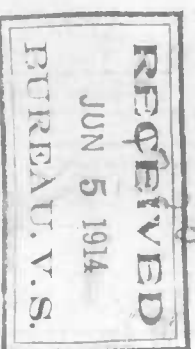
[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Plumber*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc.. *Carcin-*

oma, *Sarcoma*, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means or injury and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH

4574

County

Balt.

Village or City

Cella

(No.

St.

Ward)

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No.

30

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME

(Still born) child of George W. Bier

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 SINGLE,
MARRIED,
WIDOWED,
ORDIVORCED
(Write the word)

Single

6 DATE OF BIRTH

May 12, 1914
(Month) (Day) (Year)

7 AGE

X yrs. X mos. X ds.

If LESS than
1 day, hrs.
OR min. ?

8 OCCUPATION

(a) Trade, profession, or particular kind of work

none

(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE

(State or country)

Maryland

10 NAME OF FATHER

George W. Bier

11 BIRTHPLACE OF FATHER

(State or country)

Missouri

12 MAIDEN NAME OF MOTHER

Jessie Becraft

13 BIRTHPLACE OF MOTHER

(State or country)

Maryland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

George W. Bier

(Address)

Cella Balt. Co. Md.

15

Filed

May 12, 1914 Maishell B. Woot

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

May 12, 1914
(Month) (Day) (Year)

17

I HEREBY CERTIFY, That I attended deceased from

191 to 191

that I last saw him alive on 191

and that death occurred on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Still born

(Duration) yrs. mos. ds.

Contributory

Secondary

(Duration) yrs. mos. ds.

(Signed)

Wm. M. Gorman, M. D.

May 12, 1914 (Address) Cella, Balt. Co. Md.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted,

If not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Cella Cemetery

May 12, 1914

20 UNDERTAKER

ADDRESS

S. Hillsinger Roy Cella, Balt. Co. Md.

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

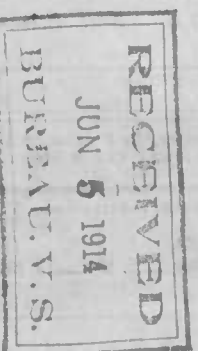
[Approved by U. S. Census and American Public Health Association.]

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Statement of cause of death—Name, first, the MISASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Typhoid cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tubercles of lungs*, *meninges*, *peritoneum*, etc., *Carcin-*

oma, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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1 PLACE OF DEATH

4575

County

Batts

Village or City

Pleasant Hill

(No.

Md

Registration Dist. No.

33

St.; Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME

Williams IC Bitzer

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

white

5 SINGLE,

MARRIED,
WIDOWED,
OR DIVORCED
(Write the word)

widower

6 DATE OF BIRTH

Oct 3, 1847

(Month)

(Day)

(Year)

7 AGE

67 yrs 7 mos

ds.

It LESS than
1 day.....hrs.
OR.....mo.?

8 OCCUPATION

(a) Trade, profession, or particular kind of work

Express Business

(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE

(State or country)

Batts co Md

PARENTS

10 NAME OF FATHER

Samuel Bitzer

11 BIRTHPLACE OF FATHER

(State or country)

Penna

12 MAIDEN NAME OF MOTHER

Sarah A. Gardner

13 BIRTHPLACE OF MOTHER

(State or country)

Penna

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Arthur Bitzer

(Address)

Owings Mills Md

15

Filed

May 4, 1914

REGISTRAR

STATE OF MARYLAND
CERTIFICATE OF DEATH

120

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No.

33

St.; Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

May 3rd, 1914

(Month)

(Day)

(Year)

17 I HEREBY CERTIFY, That I attended deceased from

May 1st, 1914, to May 3rd, 1914.

that I last saw him alive on May 2nd, 1914.

and that death occurred on the date stated above, at 2:30 a.m.

The CAUSE OF DEATH* was as follows:

Chronic interstitial nephritis

(Duration) 6 yrs. mos. ds.

Contributory

Secondary

Chronic disease affected heart causing sudden death

(Duration) yrs. mos. ds.

(Signed) W. H. Campbell, M. D.

May 4, 1914 (Address) Owings Mills, Md

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. State yrs. mos. ds.

Where was disease contracted, If not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Pleasant Hill Cemetery May 5, 1914

20 UNDERTAKER

ADDRESS

J. F. Eburne Reelutator

If more blanks are needed, address State Registrar, 6 B. Franklin St., Balto., Requesting V. S. No. 1.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

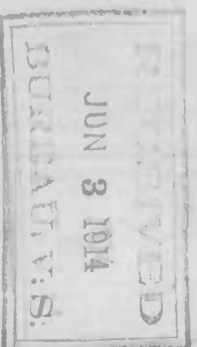
[Approved by U. S. Census and American Public Health Association.]

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Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc., Carcin-*

oma, Sarcoma, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Con-fenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæ-mia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent DEATHS state MEANS OF INJURY and quality as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carboic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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1 PLACE OF DEATH

4576

County BaltimoreVillage or City St. Agnes Hospital (No. _____)

St. _____ Ward _____

STATE OF MARYLAND
CERTIFICATE OF DEATHRegistration Dist. No. 421

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME Rena Bloecher

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White5 SINGLE,
MARRIED,
WIDOWED,
OR DIVORCED
(Write the word)Single

6 DATE OF BIRTH

March 24, 1903
(Month) (Day) (Year)

7 AGE

11 yrs. 2 mos. 17 ds. OR 1 day, _____ hrs. _____ min. ?

8 OCCUPATION

(a) Trade, profession, or particular kind of work

School Boy

(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE
(State or country)Balto

PARENTS

10 NAME OF FATHER

Frederick Bloecher11 BIRTHPLACE OF FATHER
(State or country)Balto

12 MAIDEN NAME OF MOTHER

Anne Berger13 BIRTHPLACE OF MOTHER
(State or country)Balto

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs. Fred Bloecher(Address) 897 N. Lombard St.

15

Filed May 7, 1914 Geo. Thurant

REGISTRAR

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

May 7, 1914
(Month) (Day) (Year)17 I HEREBY CERTIFY, That I attended deceased from May 2, 1914, to May 7, 1914.that I last saw him alive on May 7, 1914.and that death occurred on the date stated above, at 8-15 A.M.

The CAUSE OF DEATH* was as follows:

mitral Regurgitation(Duration) 3 yrs. ? mos. ? ds.Contributory
SecondaryAcute dilatation of heart(Duration) ? yrs. ? mos. ? ds.(Signed) Walter G. Osterdorf, M. D.May 7, 1914 (Address) St. Agnes Hospital

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds.

Where was disease contracted, If not at place of death?

Former or usual residence _____

19 PLACE OF BURIAL OR REMOVAL

Paulm Park

DATE OF BURIAL

May 10, 1914

20 UNDERTAKER

A. Jones

ADDRESS

833 Linden

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

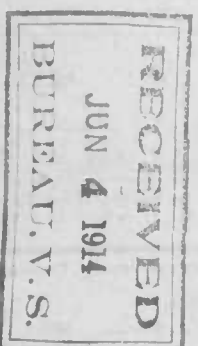
[Approved by U. S. Census and American Public Health Association.]

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oma, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 20 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-theuia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory" (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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1 PLACE OF DEATH

4577

County

Baltimore

STATE OF MARYLAND
CERTIFICATE OF DEATH

39

Registration Dist. No. _____

Village or City Near Sunnybrook (No. _____)

St.; _____ Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME

Nicholas Bode

PERSONAL AND STATISTICAL PARTICULARS

3 SEX <u>Male</u>	4 COLOR OR RACE <u>White</u>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) <u>Married</u>
6 DATE OF BIRTH <u>October 14th</u> , 18 <u>63</u> (Month) (Day) (Year)		
7 AGE <u>51</u> yrs. <u>6</u> mos. <u>16</u> ds.		If LESS than 1 day, _____ hrs. OR _____ min. ?
8 OCCUPATION (a) Trade, profession, or particular kind of work <u>Farmer</u> (b) General nature of industry, business, or establishment in which employed (or employer)		

PARENTS	9 BIRTHPLACE (State or country) <u>Balto. Co. Md.</u>
	10 NAME OF FATHER <u>Conrad Bode</u>
	11 BIRTHPLACE OF FATHER (State or country) <u>Germany</u>
	12 MAIDEN NAME OF MOTHER <u>Barbara Spring</u>
	13 BIRTHPLACE OF MOTHER (State or country) <u>Germany</u>

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Mrs. Lena Bode

(Address)

Phoenix Md.

15

Filed

May 2nd 1914J. T. Payne

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH <u>May 1st</u> , 191 <u>4</u> (Month) (Day) (Year)	17 I HEREBY CERTIFY, That I attended deceased from <u>Apr 16th</u> , 191 <u>4</u> , to <u>May 1st</u> , 191 <u>4</u> , that I last saw h <u>in</u> alive on <u>May 1st</u> , 191 <u>4</u> , and that death occurred on the date stated above, at <u>11:30</u> a.m. The CAUSE OF DEATH* was as follows:
--	---

<u>Potus Pneumonia</u> <u>and</u> <u>infection</u>	(Duration) _____ yrs. _____ mos. _____ ds.
--	--

Contributory
Secondary

(Signed) <u>J. T. Payne</u> , M. D. <u>May 2nd 1914</u> (Address) <u>Phoenix Md.</u>	(Duration) _____ yrs. _____ mos. <u>15</u> ds.
---	--

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents) At place of death _____ yrs. _____ mos. _____ ds. Where was disease contracted, If not at place of death? Former or usual residence _____	In the _____ State _____ yrs. _____ mos. _____ ds.
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19 PLACE OF BURIAL OR REMOVAL <u>St. John's Cem. Long Green Md.</u>	DATE OF BURIAL <u>May 4th</u> , 191 <u>4</u>
20 UNDERTAKER <u>Slade Bros.</u>	ADDRESS <u>Long Green Md.</u>

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Cool mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcin-*

oma, Sarcoma, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

RECEIVED

MAY 6 1914

BUREAU, U. S.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH County <u>Balto.</u>		4578	105		STATE OF MARYLAND CERTIFICATE OF DEATH	
Village or City <u>Arbutus</u>		(No. <u> </u>)	St. <u> </u> Ward <u> </u>		Registration Dist. No. <u>42</u>	
2 FULL NAME <u>William E. Boulder</u>						
PERSONAL AND STATISTICAL PARTICULARS						
3 SEX <u>Male</u>	4 COLOR OR RACE <u>White</u>	5 SINGLE, MARRIED, WIDDED, OR DIVORCED <u>Widowed</u> (Write the word)				
6 DATE OF BIRTH <u>July 3, 1844</u> (Month) (Day) (Year)						
7 AGE <u>69 yrs. 10 mos. 20 ds.</u> if LESS than 1 day, hrs. OR min. ?						
8 OCCUPATION (a) Trade, profession, or particular kind of work <u>Wheelright</u> (b) General nature of industry, business, or establishment in which employed (or employer)						
9 BIRTHPLACE (State or country) <u>Kelaware</u>						
PARENTS	10 NAME OF FATHER <u>unknown</u>					
	11 BIRTHPLACE OF FATHER (State or country) <u>Kelaware</u>					
	12 MAIDEN NAME OF MOTHER <u>unknown</u>					
	13 BIRTHPLACE OF MOTHER (State or country) <u>Kelaware</u>					
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>Martha Bradfield</u> (Address) <u>Arbutus Md</u>						
15 FILED <u>May 24, 1914</u> <u>J. H. Ruhl</u> REGISTRAR						
MEDICAL CERTIFICATE OF DEATH						
16 DATE OF DEATH <u>May 23rd, 1914</u> (Month) (Day) (Year)						
17 I HEREBY CERTIFY That I attended deceased from <u>January 5th, 1914</u> to <u>May 23rd, 1914</u> that I last saw him alive on <u>May 10th, 1914</u> and that death occurred on the date stated above, at <u>11:30 a. m.</u> The CAUSE OF DEATH* was as follows: <u>Chronic Gastro Intest.</u> (Duration) <u>4 yrs. 18 mos. 18 ds.</u>						
Contributory (Secondary) <u>Semile</u> (Duration) <u>3 mos.</u>						
(Signed) <u>W. E. P. Denter</u> , M. D. <u>May 24, 1914</u> (Address) <u>Haltershop = Md.</u>						
*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.						
18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS) At place of death <u> </u> yrs. <u> </u> mos. <u> </u> ds. In the State <u> </u> yrs. <u> </u> mos. <u> </u> ds. Where was disease contracted, If not at place of death? Former or usual residence <u> </u>						
19 PLACE OF BURIAL OR REMOVAL <u>Berryville Md</u>				DATE OF BURIAL <u>May 26, 1914</u>		
20 UNDERTAKER <u>Wm. Boas</u>				ADDRESS <u>Balto. Md</u>		

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Composer*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritonaeum*, etc.. *Carcin-*

oma, *Sarcoma*, etc., of _____ (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For violent DEATHS state MEANS OF INJURY and quality as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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1 PLACE OF DEATH County <u>Baltimore</u>		4579		42		STATE OF MARYLAND CERTIFICATE OF DEATH	
Village or City <u>Chase</u>		(No. _____) St.; _____ Ward _____					
2 FULL NAME <u>Sarah Ann Rubaker Bowen</u>		Registration Dist. No. <u>44</u>					
PERSONAL AND STATISTICAL PARTICULARS				MEDICAL CERTIFICATE OF DEATH			
3 SEX <u>Female</u>	4 COLOR OR RACE <u>colored</u>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) <u>widowed</u>		16 DATE OF DEATH <u>May 9</u> , 191 <u>4</u> (Month) (Day) (Year)			
6 DATE OF BIRTH _____, 18 <u>49</u> (Month) (Day) (Year)		7 AGE <u>65</u> yrs. — mos. — ds. If LESS than 1 day, _____ hrs. OR _____ mo. ?		17 I HEREBY CERTIFY, That I attended deceased from _____, 191 <u>1</u> , to <u>May 9</u> , 191 <u>4</u> , that I last saw her alive on <u>May 19</u> , 191 <u>4</u> , and that death occurred on the date stated above, at <u>2:45 P.</u> m.			
8 OCCUPATION (a) Trade, profession, or particular kind of work. (b) General nature of industry, business, or establishment in which employed (or employer)		<u>Housewife</u>		The CAUSE OF DEATH* was as follows: <u>Carcinoma of Uterus</u> (Duration) <u>3</u> yrs. — mos. — ds.			
9 BIRTHPLACE (State or country)		<u>Balto City</u>		Contributory (Secondary) (Duration) _____ yrs. — mos. — ds.			
10 NAME OF FATHER <u>Unknown</u>		11 BIRTHPLACE OF FATHER (State or country)		(Signed) <u>Charles R. ...</u> M. D. <u>May 9</u> , 191 <u>4</u> (Address) <u>Edgewood Md</u>			
12 MAIDEN NAME OF MOTHER <u>Unknown</u>		13 BIRTHPLACE OF MOTHER (State or country)		*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.			
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE Informant <u>Jos M. Woodward</u> (Address) <u>Chase Md</u>		15 Filed <u>May 9</u> , 191 <u>4</u> <u>J. M. ...</u> REGISTRAR		18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS) At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds. Where was disease contracted, if not at place of death? _____ Former or usual residence _____			
19 PLACE OF BURIAL OR REMOVAL <u>Chase St. ...</u>		20 DATE OF BURIAL <u>May 14</u> , 191 <u>4</u>		21 UNDERTAKER <u>Edgewood ...</u>			

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

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Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritonaeum*, etc. *Carcin-*

oma, *Sarcoma*, etc., of _____ (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.*; *Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Anemia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," "Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent DEATHS state MEANS OF INJURY and quality as ACCIDENTAL, suicidal, or homicidal, or as *probably* such. If impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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RECEIVED
JUN 6 1914
U. S. DEPT. OF COMMERCE
BUREAU OF CENSUS

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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1 PLACE OF DEATH County <u>Balto</u>		4580		174		STATE OF MARYLAND CERTIFICATE OF DEATH	
Village or City <u>Highlandtown</u>		(No. _____)		St. _____		Ward _____	
2 FULL NAME <u>Arthur Bradshaw</u>		Registered No. <u>41</u>					
PERSONAL AND STATISTICAL PARTICULARS							
3 SEX <u>male</u>	4 COLOR OR RACE <u>white</u>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) <u>single</u>		16 DATE OF DEATH <u>May 9</u> , 191 <u>4</u> (Month) (Day) (Year)			
6 DATE OF BIRTH <u>July 4</u> , 19 <u>03</u> (Month) (Day) (Year)		7 AGE <u>20</u> yrs. <u>10</u> mos. <u>5</u> ds. If LESS than 1 day, ____ hrs. OR ____ min. ?		17 I HEREBY CERTIFY, That I attended deceased from _____, 191____, to _____, 191____, that I last saw him alive on _____, 191____, and that death occurred on the date stated above, at _____ m. The CAUSE OF DEATH* was as follows:			
8 OCCUPATION (a) Trade, profession, or particular kind of work. <u>mechanic</u> (b) General nature of industry, business, or establishment in which employed (or employer) _____		9 BIRTHPLACE (State or country) <u>va</u>		Injured at the P.H. between 2 machines did an way to hospital (Duration) ____ yrs. ____ mos. ____ ds.			
10 NAME OF FATHER <u>Sam. Bradshaw</u>		11 BIRTHPLACE OF FATHER (State or country) <u>n. c.</u>		Contributory (Secondary) _____ (Duration) ____ yrs. ____ mos. ____ ds.			
12 MAIDEN NAME OF MOTHER <u>Lena Cooper</u>		13 BIRTHPLACE OF MOTHER (State or country) <u>va</u>		(Signed) <u>A. M. Wenger</u> , M. D. <u>May 9</u> , 191 <u>4</u> (Address) <u>Corcoran</u>			
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>Mrs. F. B. Louhard</u> (Address) <u>1610 N. N. W.</u>		15 FILED <u>May 9</u> , 191 <u>4</u> <u>W. C. McQuinn</u> REGISTRAR		*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.			
16 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS) At place of death ____ yrs. ____ mos. ____ ds. In the State ____ yrs. ____ mos. ____ ds. Where was disease contracted, if not at place of death? _____ Former or usual residence _____		17 PLACE OF BURIAL OR REMOVAL <u>LOUDON PARK</u>		DATE OF BURIAL <u>MAY 2</u> , 191 <u>4</u>			
18 UNDERTAKER <u>ARMSTRONG-DENNY CO.</u>		ADDRESS <u>715 Light St</u>					

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

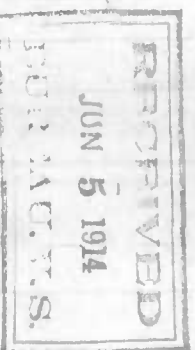
[Approved by U. S. Census and American Public Health Association.]

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Statement of cause of death—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc. *Carcin-*

oma, *Sarcoma*, etc., of _____ (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Anæmia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congential," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

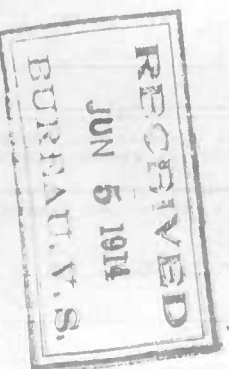
[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mining*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc. *Carcin-*

oma, *Sarcoma*, etc., of _____ (name organ; "Gaster" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Anæmia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congential," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Œmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state MEANS OF INJURY and quality as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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1 PLACE OF DEATH 4582
County Baltimore

Village or City Parkton (No., St.; Ward)

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No. 86

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME David Brightbill

PERSONAL AND STATISTICAL PARTICULARS

3 SEX male 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) widowed

6 DATE OF BIRTH December 9, 1835
(Month) (Day) (Year)

7 AGE 79 yrs. 4 mos. 25 ds. If LESS than 1 day, hrs. OR min. ?

8 OCCUPATION (a) Trade, profession, or particular kind of work Retired R.R. Car
(b) General nature of industry, business, or establishment in which employed (or employer) Inspector

9 BIRTHPLACE (State or country) Pennsylvania

10 NAME OF FATHER Nicholas Brightbill

11 BIRTHPLACE OF FATHER (State or country) Pennsylvania

12 MAIDEN NAME OF MOTHER Ann Lentz

13 BIRTHPLACE OF MOTHER (State or country) Pennsylvania

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Lewis Tipton

(Address) Parkton Md

15 Filed May 4, 1914

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH May 3rd, 1914
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from March 15, 1914 to May 3, 1914

that I last saw him alive on April 30, 1914

and that death occurred on the date stated above, at 2:30 A.M.

The CAUSE OF DEATH* was as follows:
Senile Ataxia

(Duration) yrs. mos. ds.

Contributory (Secondary) acute dehydration

(Duration) yrs. mos. ds.

(Signed) W. H. Hyde, M. D.

May 4, 1914 (Address) Parkton Md

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, If not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL Chestnut Hill Cem Maryland DATE OF BURIAL May 5th, 1914

20 UNDERTAKER E. Leroy Stuffer ADDRESS Parkton Md

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

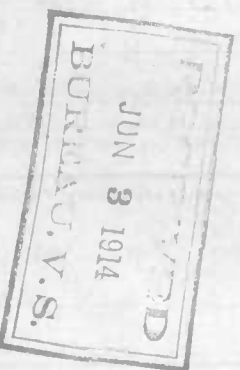
[Approved by U. S. Census and American Public Health Association.]

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Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritonaeum*, etc., *Carcin-*

oma, *Sarcoma*, etc., of _____ (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congestial," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "Puerperal septicemia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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1 PLACE OF DEATH County <u>Baltimore</u>		4583	(120)		STATE OF MARYLAND CERTIFICATE OF DEATH		Registered No. <u>58</u>
Village or City <u>Ruxton</u>		(No.)	St;		Ward)		(If death occurred in a hospital or institution, give its NAME instead of street and number.)
2 FULL NAME <u>Mary Alice Brooks</u>							
PERSONAL AND STATISTICAL PARTICULARS							
3 SEX <u>Female</u>	4 COLOR OR RACE <u>White</u>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) <u>Single</u>					
6 DATE OF BIRTH <u>4</u> <u>19</u> <u>1838</u> (Month) (Day) (Year)							
7 AGE <u>76</u> yrs. <u>1</u> mos. <u>5</u> ds. If LESS than 1 day, hrs. OR min. 2							
8 OCCUPATION (a) Trade, profession, or particular kind of work. <u>none</u> (b) General nature of industry, business, or establishment in which employed (or employer)							
9 BIRTHPLACE (State or country) <u>Balto. Md</u>							
PARENTS	10 NAME OF FATHER <u>John Brooks</u>						
	11 BIRTHPLACE OF FATHER (State or country) <u>Balto Md</u>						
	12 MAIDEN NAME OF MOTHER <u>Mary Hough</u>						
13 BIRTHPLACE OF MOTHER (State or country) <u>Balto Md</u>							
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE Informant, <u>Mary E. Mathews</u> (Address) <u>925 N. Charles St.</u>							
15 Filed <u>May 25</u> 191 <u>4</u> <u>4 M. G. Porter</u> <u>Deputy Local</u> REGISTRAR If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.							
MEDICAL CERTIFICATE OF DEATH							
16 DATE OF DEATH <u>May 25</u> , 191 <u>4</u> (Month) (Day) (Year)							
17 I HEREBY CERTIFY That I attended deceased from <u>Jan</u> , 191 <u>4</u> , to <u>May 24</u> , 191 <u>4</u> , that I last saw him alive on <u>May 12</u> , 191 <u>4</u> , and that death occurred on the date stated above, at <u>10 P.</u> m. The CAUSE OF DEATH* was as follows: <u>Myocarditis, Heart & Insuffici</u> <u>Myocarditis, Dilatation (Chronic)</u> (Duration) yrs. <u>2</u> mos. ds. Contributory (Secondary) <u>Chronic nephritis</u> (Duration) <u>9</u> yrs. mos. ds. (Signed) <u>C. B. ...</u> , M. D. <u>May 25</u> , 191 <u>4</u> . (Address) <u>Baltimore</u>							
*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.							
18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS) At place of death yrs. mos. ds. In the State yrs. mos. ds. Where was disease contracted, If not at place of death? Former or usual residence.							
19 PLACE OF BURIAL OR REMOVAL <u>Green Mt Cemetery</u>				DATE OF BURIAL <u>May 25</u> , 191 <u>4</u>			
20 UNDERTAKER <u>Stewart & Mowbray Co</u>				ADDRESS <u>215 Park ave</u>			

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

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Statement of cause of death—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritonaeum*, etc. *Carcin-*

oma, *Sarcoma*, etc., of (name origin: "Oancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.*; *Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Anemia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Insidious," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "Puerperal septicemia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and qualify as accidental, suicidal, or homicidal, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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RECEIVED

JUN 5 1914

BUREAU, V. S.

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1 PLACE OF DEATH

4584

County

Baltimore

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No. 30

Village or City

Leatonville Spring Brook St. Wd.

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME

Edward Burton

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 SINGLE,
MARRIED,
WIDOWED,
ORDIVORCED
(Write the word)

Single

6 DATE OF BIRTH

July 31, 1890
(Month) (Day) (Year)

7 AGE

23 yrs. 9 mos. 17 ds. OR LESS than 1 day, hrs. min. ?

8 OCCUPATION

(a) Trade, profession, or particular kind of work

None

(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE
(State or country)

Maryland

PARENTS

10 NAME OF FATHER

Benj. Burton

11 BIRTHPLACE OF FATHER
(State or country)

Maryland

12 MAIDEN NAME OF MOTHER

Mary Kirkendall

13 BIRTHPLACE OF MOTHER
(State or country)

Maryland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Benj. Burton

(Address)

Hannellon, Md.

15

Filed

May 17, 1914 Marshall B. West

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

May 16, 1914
(Month) (Day) (Year)

17 I HEREBY CERTIFY That I attended deceased from

May 20, 1914 to May 16, 1914

that I last saw him alive on May 16, 1914

and that death occurred on the date stated above, at 7 P. M.

The CAUSE OF DEATH* was as follows:

Status Epilepticus

(Duration) yrs. mos. 10 mos.

Contributory
Secondary

Epileptic Insult

(Duration) yrs. mos. ds.

(Signed)

J. Percy Wade, M. D.

May 17, 1914 (Address) Catonsville, Md.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, OR HOMICIDAL.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death yrs. 11 mos. 24 ds. In the State yrs. mos. ds.

Where was disease contracted?
If not at place of death?

Former or usual residence. Walter G. M. D.

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Fowler Family Cemetery May 19, 1914

20 UNDERTAKER

ADDRESS

Fred Lassalle Davis Fullerton Ind.

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

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oma, Sarcoma, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic tubular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for violent deaths state MEANS OF INJURY and qualify as ACCIDENTAL, STUPIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carboic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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BUREAU U. S.

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1 PLACE OF DEATH County <u>Baltimore</u>		4585	STATE OF MARYLAND CERTIFICATE OF DEATH Registration Dist. No. <u>1114</u>	
Village or City <u>Spencertown, W. E.</u>		No. <u>9</u>	St. <u>W. E.</u>	Ward <u>9</u>
2 FULL NAME <u>Frank A. Cuneal</u>				
PERSONAL AND STATISTICAL PARTICULARS				
3 SEX <u>M.</u>	4 COLOR OR RACE <u>W.</u>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) <u>Married</u>		
6 DATE OF BIRTH <u>June 3, 1882</u> (Month) <u>3</u> (Day) <u>3</u> (Year) <u>1882</u>				
7 AGE <u>31</u> yrs. <u>11</u> mos. <u>24</u> ds. If LESS than 1 day, hrs. OR min. ?				
8 OCCUPATION (a) Trade, profession, or particular kind of work <u>Train worker</u> (b) General nature of industry, business, or establishment in which employed (or employer) <u>B</u>				
9 BIRTHPLACE (State or country) <u>Balto. Md</u>				
PARENTS	10 NAME OF FATHER <u>Not Known</u>			
	11 BIRTHPLACE OF FATHER (State or country) <u>Not Known</u>			
	12 MAIDEN NAME OF MOTHER <u>Alice Neal</u>			
13 BIRTHPLACE OF MOTHER (State or country) <u>Balto Md.</u>				
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>Susanne M. Gray</u> (Address) <u>2651 Md E</u>				
15 FILED <u>May 27, 1914</u> <u>G. H. McCormick</u> REGISTRAR				
MEDICAL CERTIFICATE OF DEATH				
16 DATE OF DEATH <u>May 27</u> , 191 <u>4</u> (Month) (Day) (Year)				
17 I HEREBY CERTIFY, That I attended deceased from <u>July</u> , 191 <u>2</u> , to <u>May 27</u> , 191 <u>4</u> . that I last saw him alive on <u>May 27</u> , 191 <u>4</u> . and that death occurred on the date stated above, at <u>1.15 P.</u> m. The CAUSE OF DEATH* was as follows: <u>Pulmonary Tuberculosis</u>				
(Duration) <u>4</u> yrs. <u>4</u> mos. <u>4</u> ds.				
Contributory Secondary <u>Exhaustion</u>				
(Duration) <u>4</u> yrs. <u>4</u> mos. <u>4</u> ds.				
(Signed) <u>Frank C. Cuneal</u> , M. D. <u>May 27, 1914</u> (Address) <u>Spencertown</u>				
State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.				
18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS) At place of death <u>4</u> yrs. <u>4</u> mos. <u>4</u> ds. In the State <u>4</u> yrs. <u>4</u> mos. <u>4</u> ds. Where was disease contracted, If not at place of death? Former or usual residence				
19 PLACE OF BURIAL OR REMOVAL <u>Baltimore Cem.</u>			DATE OF BURIAL <u>May 28, 1914</u>	
20 UNDERTAKER <u>W. C. Book</u>			ADDRESS <u>5028 North</u>	
If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.				

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

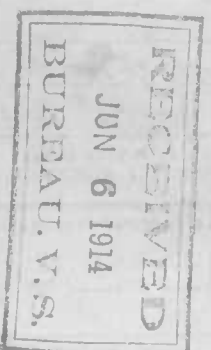
[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not faithfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcin-*

oma, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.



WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH 4586
County Balto

Village or City White Hall (No. _____, St.; _____ Ward)

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No. 10 39

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME Lilhe Louise Cammel

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE Black 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) Married

6 DATE OF BIRTH July 12, 1888
(Month) (Day) (Year)

7 AGE 25 yrs. 11 mos. 28 ds. 17 LESS than 1 day.....hrs. OR.....mo. ?

8 OCCUPATION
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer) _____

9 BIRTHPLACE (State or country) Balto

10 NAME OF FATHER Melchor Davis

11 BIRTHPLACE OF FATHER (State or country) Harford Md

12 MAIDEN NAME OF MOTHER Lizer Scott

13 BIRTHPLACE OF MOTHER (State or country) Balto Md

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Arthur W. Payne
(Address) White Hall Md

15 Filed May 12, 1914 J. T. Payne
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH May 11, 1914
(Month) (Day) (Year)

17 I HEREBY CERTIFY that I attended deceased from May 9, 1914 to May 10, 1914
that I last saw her alive on May 10, 1914

and that death occurred on the date stated above, at 1:20 P. M.
The CAUSE OF DEATH* was as follows:

Epilepsy

(Duration) 20 yrs. mos. ds.
Contributory (Secondary) Continuous Convulsions
(Signed) T. Ross Payne M. D.

(Duration) 4 yrs. mos. ds.
(Address) Chesley Md.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds.

Where was disease contracted, if not at place of death? _____

Former or usual residence _____

19 PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Int. Gory May 12, 1914

20 UNDERTAKER ADDRESS

S. M. Shickel White Hall Md

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

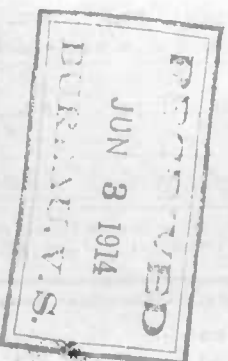
[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Group"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc.. *Carcin-*

oma, *Sarcoma*, etc., of _____ (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Anemia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congential," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state MEANS OF INJURY and quality as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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1 PLACE OF DEATH 4587

County BaltimoreVillage or City Catonsville (No. Bushwood Ave St.; Ward)STATE OF MARYLAND
CERTIFICATE OF DEATHRegistration Dist. No. 30

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME George Sumnerville Christoff

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) Married

6 DATE OF BIRTH August 10th, 1894
(Month) (Day) (Year)

7 AGE 69 yrs. 9 mos. 11 ds. If LESS than 1 day, hrs. OR min. ?

8 OCCUPATION
(a) Trade, profession, or particular kind of work Journalist
(b) General nature of industry, business, or establishment in which employed (or employer) —

9 BIRTHPLACE (State or country) Baltimore City

PARENTS
10 NAME OF FATHER George H. Christoff
11 BIRTHPLACE OF FATHER (State or country) Baltimore Md
12 MAIDEN NAME OF MOTHER Frances W. Christoff
13 BIRTHPLACE OF MOTHER (State or country) Baltimore Md

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Margaret C. Christoff
(Address) Catonsville

15 Filed May 21, 1914 Marshall B. West
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH May 21st, 1914
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from May 7th, 1914 to May 21st, 1914, that I last saw him alive on May 21st, 1914.

and that death occurred on the date stated above, at 9:10 A. M.

The CAUSE OF DEATH* was as follows:

Hypertrophy of heart and
hypertension

(Duration) 3 yrs. — mos. — ds.
Contributory Insufficiency of heart
Secondary arteriosclerosis

(Signed) J. C. H. Moffatt, M. D.
May 21st, 1914 (Address) Catonsville Md

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death — yrs. — mos. — ds. In the State — yrs. — mos. — ds.

Where was disease contracted, If not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL Mt Olivet DATE OF BURIAL May 23, 1914

20 UNDERTAKER J. B. Block ADDRESS 1033 W. Main St

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

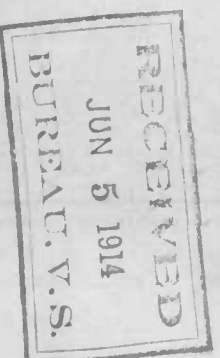
[Approved by U. S. Census and American Public Health Association.]

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Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritonaeum*, etc., *Carcin-*

oma, Sarcoma, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congential," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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1 PLACE OF DEATH <i>Baltimore</i> 4588		STATE OF MARYLAND CERTIFICATE OF DEATH	
County <i>Baltimore</i>		Registration Dist. No. <i>444</i>	
Village or City <i>Sparrows Point</i> (No. <i>11</i> , <i>Baltimore</i> St.; Ward)		[If death occurred in a hospital or institution, give its NAME instead of street and number.]	
2 FULL NAME <i>Still born infant Clark</i>			
PERSONAL AND STATISTICAL PARTICULARS			
3 SEX <i>Male</i>	4 COLOR OR RACE <i>White</i>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) <i>Single</i>	
6 DATE OF BIRTH <i>May 26th</i> , 1914 (Month) (Day) (Year)			
7 AGE — yrs. — mos. — ds.		It LESS than 1 day <input checked="" type="checkbox"/> hrs. OR <input type="checkbox"/> mn. ?	
8 OCCUPATION (a) Trade, profession, or particular kind of work <i>none</i> (b) General nature of Industry, business, or establishment in which employed (or employer) <i>none</i>			
9 BIRTHPLACE (State or country) <i>Sparrows Point</i>			
PARENTS	10 NAME OF FATHER <i>James Clark</i>		
	11 BIRTHPLACE OF FATHER (State or country) <i>Del.</i>		
	12 MAIDEN NAME OF MOTHER <i>Dorothy Carr</i>		
	13 BIRTHPLACE OF MOTHER (State or country) <i>Md.</i>		
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Intormant) <i>Mrs James Clark</i> (Address) <i>Sparrows Point</i>			
15 Filed <i>May 27th</i> , 1914 <i>J. Mc Cormick M.D.</i> REGISTRAR			
MEDICAL CERTIFICATE OF DEATH			
16 DATE OF DEATH <i>May 26th</i> , 1914 (Month) (Day) (Year)			
17 I HEREBY CERTIFY, That I attended deceased from <i>191</i> to <i>191</i> that I last saw h. <i>alive on</i> , 191 and that death occurred on the date stated above, at <i>m</i> . The CAUSE OF DEATH* was as follows: <i>still born infant (4th month)</i> (Duration) <i>—</i> yrs. <i>—</i> mos. <i>—</i> ds.			
Contributory Secondary <i>Syphilis</i> (Duration) <i>—</i> yrs. <i>—</i> mos. <i>—</i> ds.			
(Signed) <i>J. Mc Cormick M.D.</i> , M. D. <i>May 27</i> , 1914 (Address) <i>Sparrows Point</i>			
*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.			
18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS) At place of death <i>—</i> yrs. <i>—</i> mos. <i>—</i> ds. In the State <i>—</i> yrs. <i>—</i> mos. <i>—</i> ds. Where was disease contracted, If not at place of death? Former or usual residence <i>—</i>			
19 PLACE OF BURIAL OR REMOVAL <i>sent to Johns Hopkins Anatomy.</i>		DATE OF BURIAL <i>—</i> , 191	
20 UNDERTAKER <i>Laboratory.</i>		ADDRESS	

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

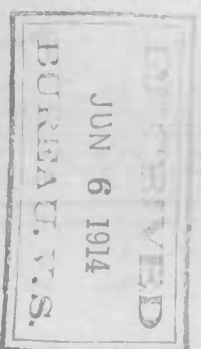
[Approved by U. S. Census and American Public Health Association.]

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1 PLACE OF DEATH

County BaltimoreVillage or City Fullerton (No. 461 92 CH St.; Ward)STATE OF MARYLAND
CERTIFICATE OF DEATHRegistration Dist. No. 43

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME Mary L. Glass

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) Widowed

6 DATE OF BIRTH 4 23, 1849
(Month) (Day) (Year)

7 AGE 65 yrs. — mos. 7 ds. OR — min. ?
It LESS than 1 day, — hrs.

8 OCCUPATION
(a) Trade, profession, or particular kind of work House Duties
(b) General nature of industry, business, or establishment in which employed (or employer) None

9 BIRTHPLACE (State or country) Europe

10 NAME OF FATHER Christopher Diemer

11 BIRTHPLACE OF FATHER (State or country) Europe

12 MAIDEN NAME OF MOTHER Elisa Steinmeier

13 BIRTHPLACE OF MOTHER (State or country) Europe

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Charles F. Glass(Address) Lansdown R. F. D. No. 6

15 Filed May 3, 1914 M. H. Myer
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH 5 1, 1914
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from April 25, 1914 to May 1, 1914, that I last saw her alive on April 25, 1914

and that death occurred on the date stated above, at 120 a. m.
The CAUSE OF DEATH* was as follows:

Lobar Pneumonia
J. B.

(Duration) 5 yrs. — mos. — ds.
Contributory Myocardial Degeneration
Secondary

(Signed) Harry L. King, M. D.
May 1, 1914 (Address) Hamilton Md

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death — yrs. — mos. — ds. In the State — yrs. — mos. — ds.

Where was disease contracted, It not at place of death?

Former or usual residence.

19 PLACE OF BURIAL OR REMOVAL St. Johns Cemetery DATE OF BURIAL May 3, 1914

20 UNDERTAKER Frederick Lassahn ADDRESS Say Fullerton Md

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

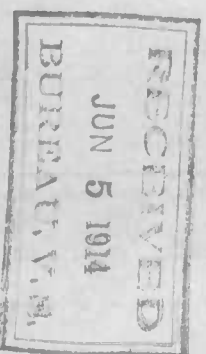
[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mining*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcin-*

oma, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congential," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal *septicæmia*," "Puerperal *peritonitis*," etc. State cause for which surgical operation was undertaken. For violent deaths state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbonic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.



WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very Important. See instructions on back of certificate.

1 PLACE OF DEATH

4589

County BaltoVillage or City Pikesville (No. Soldier's Home St.; Ward)STATE OF MARYLAND
CERTIFICATE OF DEATHRegistered No. 32

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME

William A. Coale

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Married
(Write the word)6 DATE OF BIRTH May 1837
(Month) (Day) (Year)7 AGE 77 yrs. 0 mos. 0 ds. If LESS than 1 day, hrs. 0 min. ?8 OCCUPATION
(a) Trade, profession, or particular kind of work Retired
(b) General nature of industry, business, or establishment in which employed (or employer) Soldier9 BIRTHPLACE (State or country) Md.10 NAME OF FATHER Unknown11 BIRTHPLACE OF FATHER (State or country) Md.12 MAIDEN NAME OF MOTHER Unknown13 BIRTHPLACE OF MOTHER (State or country) Unknown

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15 Filed 5/7, 1914 Henry A. Maynor
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH May 3, 1914
(Month) (Day) (Year)17 I HEREBY CERTIFY, That I attended deceased from for many years, 1914, that I last saw him alive on May 3, 1914and that death occurred on the date stated above, at 6 P. m.
The CAUSE OF DEATH* was as follows:Nervous heart diseaseContributory (Secondary) Senior debility (Duration) many yrs. mos. ds.(Signed) W. E. May (Duration) 0 yrs. 0 mos. 0 ds., M. D.
May 4, 1914 (Address) Pikesville

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death 0 yrs. 0 mos. 0 ds. In the State 0 yrs. 0 mos. 0 ds.

Where was disease contracted, If not at place of death?

Former or usual residence 3219 PLACE OF BURIAL OR REMOVAL Cathedral Cemetery DATE OF BURIAL May 6, 191420 UNDERTAKER John F. Cowan ADDRESS 901 Hollins

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

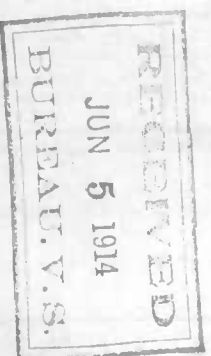
[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc. *Carcin-*

oma, *Sarcoma*, etc., of _____ (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Anemia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congential," "Senile" etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, suicidal, or homicidal, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

4590

1 PLACE OF DEATH

County Baltimore CountyVillage or City Owensville (No. 102 N. 11th)STATE OF MARYLAND
CERTIFICATE OF DEATHRegistration Dist. No. 41

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME George W. Coburn

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Single
(Write the word)

6 DATE OF BIRTH May 5, 1900
(Month) (Day) (Year)7 AGE 14 yrs. — mos. 16 ds. If LESS than 1 day, hrs. OR min. ?

8 OCCUPATION
(a) Trade, profession, or particular kind of work School Boy
(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE (State or country) Md10 NAME OF FATHER Thomas H. Coburn11 BIRTHPLACE OF FATHER (State or country) Md12 MAIDEN NAME OF MOTHER Mary E. A. Adams13 BIRTHPLACE OF MOTHER (State or country) Md

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Geo. W. Coburn(Address) 102 N. 11th St15 Filed May 21, 1914 W. E. McClanahanREGISTRAR W. E. McClanahan

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH May 21, 1914
(Month) (Day) (Year)17 I HEREBY CERTIFY, That I attended deceased from May 12, 1914, to May 21, 1914, that I last saw him alive on May 21, 1914and that death occurred on the date stated above, at 7 a m.
The CAUSE OF DEATH* was as follows:Croupous Pneumonia(Duration) — yrs. — mos. 10 ds.

Contributory Secondary

(Duration) — yrs. — mos. — ds.(Signed) Henry D. Heber, M. D.
721, 1914 (Address) 200 N. Path. Pl. Co.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death — yrs. — mos. — ds. In the State — yrs. — mos. — ds.

Where was disease contracted, If not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL Oak Lawn Cemetery DATE OF BURIAL May 24, 191420 UNDERTAKER Robert Miller ADDRESS 2334 Jefferson

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mining*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcin-*

oma, Sarcoma, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congital," "Senile" etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Hemiplegia," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state MEANS OF INJURY and qualify as ACCIDENTAL, SOCIAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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RECEIVED
JUN 5 1914
BUREAU, V.S.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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1 PLACE OF DEATH <u>4591</u>		STATE OF MARYLAND	
County <u>Baltimore</u>		CERTIFICATE OF DEATH	
Village or City <u>Catonsville Neck</u>		Registration Dist. No. <u>44</u>	
2 FULL NAME <u>Medora Jackson Cole</u>		[If death occurred in a hospital or institution, give its NAME instead of street and number.]	
PERSONAL AND STATISTICAL PARTICULARS			
3 SEX <u>Female</u>	4 COLOR OR RACE <u>Color</u>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED <u>Married</u> (Write the word)	
6 DATE OF BIRTH <u>July</u> —, <u>1896</u> (Month) (Day) (Year)		16 DATE OF DEATH <u>May 30</u> , 191 <u>4</u> (Month) (Day) (Year)	
7 AGE <u>17</u> yrs. <u>10</u> mos. — ds. OR <u>10</u> min. ?	17 I HEREBY CERTIFY, That I attended deceased from <u>191</u> to <u>191</u> , that I last saw him <u>alive on</u> <u>May 30</u> , 191 <u>4</u> , and that death occurred on the date stated above, at <u>11:45 P.M.</u>		
8 OCCUPATION (a) Trade, profession, or particular kind of work <u>Farm Work</u> (b) General nature of industry, business, or establishment in which employed (or employer) <u>Truck Farm</u>		The CAUSE OF DEATH* was as follows: <u>from a stab wound</u> <u>to the right breast</u> <u>Homicide</u> (Duration) — yrs. — mos. — ds.	
9 BIRTHPLACE (State or country) <u>Md</u>		Contributory Secondary (Duration) — yrs. — mos. — ds.	
PARENTS	10 NAME OF FATHER <u>Chas. Jackson</u>	(Signed) <u>W. H. Keys</u> Mayor, M. B.	
	11 BIRTHPLACE OF FATHER (State or country) <u>Md</u>	<u>5/31</u> , 191 <u>4</u> (Address) <u>Sparks Point</u>	
	12 MAIDEN NAME OF MOTHER <u>Susa Grosser</u>	*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.	
	13 BIRTHPLACE OF MOTHER (State or country) <u>Md</u>	18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS) At place of death — yrs. — mos. — ds. In the State — yrs. — mos. — ds. Where was disease contracted, If not at place of death? Former or usual residence —	
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>Chas. Jackson</u> (Address) <u>Sparks Point</u>		19 PLACE OF BURIAL OR REMOVAL <u>Ashbury Cemetery</u> DATE OF BURIAL <u>June 20</u> , 191 <u>4</u>	
15 Filed <u>May 31</u> , 191 <u>4</u> <u>G. L. McLeary</u> REGISTRAR		20 UNDERTAKER <u>Armstrong Denny & Co.</u> ADDRESS <u>Balto.</u>	

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

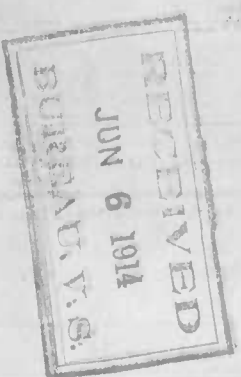
[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritonaeum*, etc., *Carcin-*

oma, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicemia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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1 PLACE OF DEATH 4592
County Balto.

Village or City Wenderson

(No. 9)

Jones Creek

Registration Dist. No. 44

St.; Ward

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME Louisa Coleman

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE Colored 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) single

6 DATE OF BIRTH Feb x 1913
(Month) (Day) (Year)

7 AGE 1 yrs. 3 mos. 8 ds. If LESS than 1 day, hrs. OR min. ?

8 OCCUPATION
(a) Trade, profession, or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer) None

9 BIRTHPLACE (State or country) Balto Co

10 NAME OF FATHER William Coleman

11 BIRTHPLACE OF FATHER (State or country) Va

12 MAIDEN NAME OF MOTHER Mary Briscoe

13 BIRTHPLACE OF MOTHER (State or country) Kud

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
Informant Eiza Grier

(Address) Elk Ave Sp Point

15 Filed June 10th 1914 G. H. McCombs

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH May 30, 1914
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from May 30, 1914, to May 30, 1914, that I last saw her alive on May 30, 1914

and that death occurred on the date stated above, at 9 P m.

The CAUSE OF DEATH* was as follows:

Exhaustion

(Duration) x yrs. x mos. 1 ds.

Contributory (Secondary) Bronchial Pneumonia

(Duration) x yrs. x mos. 1 ds.

(Signed) Jar. L. Moore N. D.

June 1, 1914 (Address) 248 So Third

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, If not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL Asbury Cemetery DATE OF BURIAL June 20, 1914

20 UNDERTAKER Armstrong Denny Co ADDRESS Balto.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

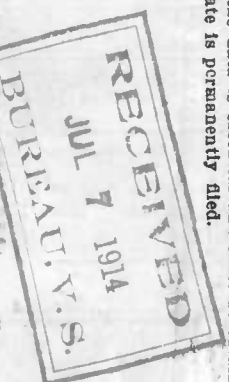
[Approved by U. S. Census and American Public Health Association.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry; and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mining*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritonaeum*, etc.. *Carcin-*

oma, Sarcoma, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *20 ds.*, *Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congential," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "Puerperal septicemia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and quality as accidental, suicidal, or homicidal, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory" (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.



G. C. MCCORMICK, M.D.

SPARROWS POINT

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH 4593

County Baltimore

912 STATE OF MARYLAND
CERTIFICATE OF DEATH

Registered No. 32

Village or City Sheppard Enoch Pratt Hospital Towson Md. (No.) Ward

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME James J. Council

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Married
(Write the word)

6 DATE OF BIRTH November 25, 1866
(Month) (Day) (Year)

7 AGE 47 yrs. 5 mos. 26 ds. If LESS than 1 day, hrs. OR min. ?

8 OCCUPATION
(a) Trade, profession, or particular kind of work Manager Brewery
(b) General nature of industry, business, or establishment in which employed (or employer) Manager Brewery

9 BIRTHPLACE (State or country) West Virginia

10 NAME OF FATHER Thomas Council

11 BIRTHPLACE OF FATHER (State or country) Ireland

12 MAIDEN NAME OF MOTHER Ann Duffy

13 BIRTHPLACE OF MOTHER (State or country) Ireland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) E. J. Council(Address) Clarksburg W. Va.

15 Filed May 22, 1914 M. G. Porter
Deputy Clerk REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH May 21, 1914
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from April 21, 1914 to May 21, 1914.

that I last saw him alive on May 20, 1914.

and that death occurred on the date stated above, at 8:30 a. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(Duration) yrs. 3 mos. 3 ds.

Contributory (Secondary) Pneumia

(Duration) yrs. 2 mos. ds.

(Signed) G. J. Sargent, M. D.

May 21, 1914 (Address) Towson Md.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, If not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL Clarksburg W. Va. DATE OF BURIAL May 23, 1914

20 UNDERTAKER Robert Brooks & Son ADDRESS Calhoun Hollister

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc.. *Carcin-*

oma, *Sarcoma*, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 *ds.*; *Bronchopneumonia* (secondary), 10 *ds.* Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state MEANS OF INJURY and qualify as ACCIDENTAL, suicidal, or homicidal, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

RECEIVED

JUN 5 1914

BUREAU, V. S.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH County <u>Baltimore</u>		4594		28		STATE OF MARYLAND CERTIFICATE OF DEATH	
Village or City <u>Westport</u>		(No. <u>233</u> <u>Potapco</u> St.; Ward)				Registration Dist. No. <u>42</u>	
2 FULL NAME <u>William B. Creamer</u>		[If death occurred in a hospital or institution, give its NAME instead of street and number.]					
PERSONAL AND STATISTICAL PARTICULARS							
3 SEX <u>male</u>	4 COLOR OR RACE <u>white</u>	5 SINGLE, MARRIED, WIDDED, OR DIVORCED <u>single</u> (Write the word)					
6 DATE OF BIRTH <u>July 7</u> , 1890 (Month) (Day) (Year)							
7 AGE <u>23</u> yrs. <u>10</u> mos. <u>?</u> ds.		If LESS than 1 day, hrs. OR min. ?					
8 OCCUPATION (a) Trade, profession, or particular kind of work <u>Laborer</u> (b) General nature of industry, business, or establishment in which employed (or employer)							
9 BIRTHPLACE (State or country) <u>New Jersey</u>							
PARENTS	10 NAME OF FATHER <u>Heather Creamer</u>						
	11 BIRTHPLACE OF FATHER (State or country) <u>New Jersey</u>						
	12 MAIDEN NAME OF MOTHER <u>Anna Barber</u>						
13 BIRTHPLACE OF MOTHER (State or country) <u>Delaware</u>							
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>Anna Morris</u> (Address) <u>Westport Md</u>							
15 Filled <u>May 7</u> , 191 <u>4</u>		REGISTRAR <u>W. R. Ruhl</u>					
MEDICAL CERTIFICATE OF DEATH							
16 DATE OF DEATH <u>May 6</u> , 191 <u>4</u> (Month) (Day) (Year)							
17 I HEREBY CERTIFY, That I attended deceased from <u>April 25</u> , 191 <u>4</u> , to <u>May 6</u> , 191 <u>4</u> , that I last saw him alive on <u>May 5</u> , 191 <u>4</u> , and that death occurred on the date stated above, at <u>2 a</u> m. The CAUSE OF DEATH* was as follows: <u>Tuberculosis of lungs.</u> (Duration) <u>2</u> yrs. <u>—</u> mos. <u>—</u> ds. Contributory (Secondary) <u>Exhaustion</u> (Duration) <u>—</u> yrs. <u>—</u> mos. <u>5</u> ds. (Signed) <u>Regina</u> , M. D. <u>May 6</u> , 191 <u>4</u> (Address) <u>not written</u>							
*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.							
18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS) At place of death <u>—</u> yrs. <u>—</u> mos. <u>—</u> ds. In the State <u>—</u> yrs. <u>—</u> mos. <u>—</u> ds. Where was disease contracted, If not at place of death? Former or usual residence							
19 PLACE OF BURIAL OR REMOVAL <u>Woodbine N. J.</u>				DATE OF BURIAL <u>May 9</u> , 191 <u>4</u>			
20 UNDERTAKER <u>William Coors</u>				ADDRESS <u>City Md</u>			

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

Approved by U. S. Census and American Public Health Association.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Composer*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mining*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Group"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritonaeum*, etc.. *Carcin-*

oma, *Sarcoma*, etc., of (name origin: "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congential," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Traema," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases, resulting from childbirth or miscarriage, as "Puerperal septicemia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory" (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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RECEIVED

JUN 4 1914

BUREAU OF VITALS

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH

4595

County Baltimore

Village or City

St Agnes Hospital (No. 120)St. WardRegistration Dist. No. 42

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME

Mr. Rufus Crooks

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White5 SINGLE,
MARRIED,
WIDDED,
OR DIVORCED
(Write the word)Married

6 DATE OF BIRTH

Jan 30, 1864
(Month) (Day) (Year)

7 AGE

50 yrs. 4 mos. 11 ds. OR 1 day, hrs. min. ?

8 OCCUPATION

(a) Trade, profession, or particular kind of work

Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

Stone Mason9 BIRTHPLACE
(State or country)Baltimore, Md.

PARENTS

10 NAME OF FATHER

Joshua Crooks11 BIRTHPLACE OF FATHER
(State or country)Maryland

12 MAIDEN NAME OF MOTHER

Mary Schuckels13 BIRTHPLACE OF MOTHER
(State or country)Do not know

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mr. R. Crooks(Address) 1113 Mount St

15

Filed May 21, 1914 Geo A Stewart

REGISTRAR

STATE OF MARYLAND
CERTIFICATE OF DEATH

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

May 31, 1914
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from

April 7, 1914 to May 31, 1914,
that I last saw him alive on May 31, 1914and that death occurred on the date stated above, at 11:15 a.m.

The CAUSE OF DEATH* was as follows:

Chronic Catarrh of the
stomach.(Duration) 3 yrs. — mos. — ds.Contributory
SecondaryChronic(Duration) — yrs. — mos. 5 ds.

(Signed)

Walter A. Ostendorf, M. D.May 31, 1914 (Address) St Agnes Hospital

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death — yrs. 1 mos. 24 ds. In the State — yrs. — mos. — ds.Where was disease contracted,
If not at place of death?Former or usual residence 1113 Mount Street

19 PLACE OF BURIAL OR REMOVAL

Western Ave

DATE OF BURIAL

Jan 2, 1914

20 UNDERTAKER

Geo A Stewart

ADDRESS

1000 W J. Light St

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

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Statement of cause of death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Typhemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcinoma*, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asphyxia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congential," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal *septicæmia*," "Puerperal *peritonitis*," etc. State cause for which surgical operation was undertaken. For violent DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, STRUCK, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carboic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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RECEIVED

JUN 4 1914

BUREAU, U. S.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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1 PLACE OF DEATH 4596
County Balto

Villages or City Highlandtown (No. 3219 Colgate St. St.; Ward)

2 FULL NAME Genevieve Virginia Dandy

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No. 41

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

PERSONAL AND STATISTICAL PARTICULARS

3 SEX female 4 COLOR OR RACE white 5 SINGLE, MARRIED, WIDDED, OR DIVORCED Single
(Write the word)

6 DATE OF BIRTH Oct 11, 1911
(Month) (Day) (Year)

7 AGE 2 yrs. 7 mos. ds. If LESS than 1 day, hrs. OR min. ?

8 OCCUPATION
(a) Trade, profession, or particular kind of work child
(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE (State or country) Balto

10 NAME OF FATHER Wm O. Dandy

11 BIRTHPLACE OF FATHER (State or country) Balto City

12 MAIDEN NAME OF MOTHER Mary A. Grimes

13 BIRTHPLACE OF MOTHER (State or country) B

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Wm O. Dandy

(Address) 3219 Colgate St

15 Filed May 25, 1914 W. W. Claiborne

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH May 24, 1914
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from May 15, 1914, to May 24, 1914, that I last saw her alive on May 23, 1914

and that death occurred on the date stated above, at 7 A m.
The CAUSE OF DEATH* was as follows:

Broncho-Pneumonia
(Duration) 4 yrs. 4 mos. ds.

Contributory (Secondary) Whooping Cough
(Duration) 3/4 yrs. mos. ds.

(Signed) Frank A. Slattery, M. D.
May 24, 1914 (Address) 3244 Eastern Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL Schmartz DATE OF BURIAL May 26, 1914

20 UNDERTAKER W. W. Claiborne ADDRESS 6036 1/2 Ave

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not faintly employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritonaeum*, etc. *Carcin-*

oma, *Sarcoma*, etc., of _____ (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 *ds.*; *Bronchopneumonia* (secondary), 10 *ds.* Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congestial," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicemia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and quality as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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RECEIVED

JUN 5 1914

BUREAU, V. S.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH

4597

90

STATE OF MARYLAND
CERTIFICATE OF DEATH

County

Batto

Registration Dist. No.

33

Village or City

near Onings Mills

(No.)

Md

St.; Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME

Mary Dauberman

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

white

5 SINGLE,

MARRIED,

WIDOWED,

OR DIVORCED

(Write the word)

widow

6 DATE OF BIRTH

Feb 16, 1811

(Month)

(Day)

(Year)

7 AGE

103 yrs. 3 mos. 19 ds.

If LESS than

1 day, hrs.

OR min. ?

8 OCCUPATION

(a) Trade, profession, or particular kind of work

none

(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE

(State or country)

Washington Co Md

PARENTS

10 NAME OF FATHER

Unknown

11 BIRTHPLACE OF FATHER (State or country)

Unknown

12 MAIDEN NAME OF MOTHER

Moncey Park

13 BIRTHPLACE OF MOTHER (State or country)

Unknown

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Mr. Edward Shomah

(Address)

Onings Mills Md

15

Filed

May 4, 1914

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

May 4, 1914

(Month)

(Day)

(Year)

17 I HEREBY CERTIFY, That I attended deceased from

May 4, 1914, to May 4, 1914,

that I last saw her alive on May 4, 1914,

and that death occurred on the date stated above, at 2:30 P. M.

The CAUSE OF DEATH* was as follows:

Chronic Bronchitis

(Duration) 3 yrs. mos. ds.

Contributory

Secondary

Inferior 2 yrs

(Duration) yrs. mos. ds.

(Signed)

J. F. Eline

M. D.

May 5, 1914. (Address) Reisterstown Md

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place

of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted,

If not at place of death?

Former or

usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Druid Ridge Cemetery

May 6, 1914

20 UNDERTAKER

ADDRESS

J. F. Eline

Reisterstown

If more blanks are needed, address State Registrar, E. Franklin St., Balto., Requesting V. S. No. 1.

119

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

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Statement of cause of death—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritonaeum*, etc., *Carcin-*

oma, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congential," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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RECEIVED
JUN 8 1914
BUREAU, V.S.

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1 PLACE OF DEATH 4598

County

Baltimore

Village or City

Overlea

(No.

St.

Ward)

Registration Dist. No.

43

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME

Caroline Deaver

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Single (Write the word)

6 DATE OF BIRTH

July 2, 1876
(Month) (Day) (Year)

7 AGE

38 yrs. 10 mos. 15 ds. OR LESS than 1 day, hrs. min. ?

8 OCCUPATION

(a) Trade, profession, or particular kind of work

None

(b) General nature of industry, business, or establishment in which employed (or employer)

None

9 BIRTHPLACE

(State or country)

Maryland

PARENTS

10 NAME OF FATHER

George K. Beaver

11 BIRTHPLACE OF FATHER

(State or country)

Maryland

12 MAIDEN NAME OF MOTHER

Sophie Lancaster

13 BIRTHPLACE OF MOTHER

(State or country)

Maryland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Alfred Chesney

(Address)

Overlea Ind.

15

Filed

May 19, 1914 W. H. Clayton

REGISTRAR

STATE OF MARYLAND
CERTIFICATE OF DEATH

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

6, 17, 1914
(Month) (Day) (Year)

17

I HEREBY CERTIFY, That I attended deceased from

5-5-1914 to 5-17-1914

that I last saw her alive on 5-14-1914

and that death occurred on the date stated above, at 8 P. M.

The CAUSE OF DEATH* was as follows:

Pulmonary Oedema

(Duration) yrs. mos. 3 ds.

Contributory

Congenital Spastic Diplegia with Locked Idiosyncrasy

(Duration) 38 yrs. 10 mos. 15 ds.

(Signed)

W. L. Wilkinson, M. D.

5-18-1914 (Address) Roselburg

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Greenmount Cemetery May 20, 1914

20 UNDERTAKER

ADDRESS

Fredk Lassahn Sons Fullerton Ind

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

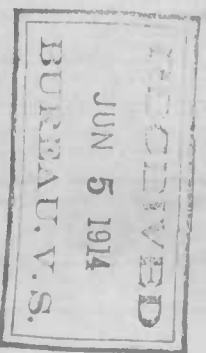
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Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcin-*

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1 PLACE OF DEATH

County

Baltimore

4599

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No.

33

Village or City

Crown Hills

(No.)

Glynbrook

St.

Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME

William H Lee Bus

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word)

Married

6 DATE OF BIRTH

Feb

(Month)

19

(Day)

1

(Year)

7 AGE

59

yrs.

mos.

ds.

If LESS than 1 day, hrs. OR min. ?

8 OCCUPATION

(a) Trade, profession, or particular kind of work

Farmer

(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE

(State or country)

Baltimore Md

PARENTS

10 NAME OF FATHER

John C Lee Bus

11 BIRTHPLACE OF FATHER

(State or country)

Germany

12 MAIDEN NAME OF MOTHER

Mary Elson

13 BIRTHPLACE OF MOTHER

(State or country)

Baltimore Md

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

John C Lee Bus

(Address)

Glynbrook

15

Filed

May 27, 1914

J. H. Lee

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

May 26th, 1914

17 I HEREBY CERTIFY, That I attended deceased from

Oct 2nd, 1913, to May 26th, 1914

that I last saw him alive on May 26th, 1914

and that death occurred on the date stated above, at 11:30 p. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Liver.

(Duration) X yrs. 7 mos. 24 ds.

Contributory Secondary

(Duration) 1 yrs. X mos. V ds.

(Signed)

L. Frank Miller M.D.

May 27th, 1914 (Address) Baltimore

State the DISEASE CAUSING DEATH, or, in deaths from VIOLENCE, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, If not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

Present Hill

DATE OF BURIAL

May 27, 1914

20 UNDERTAKER

William Cook 502 E. Main

ADDRESS

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

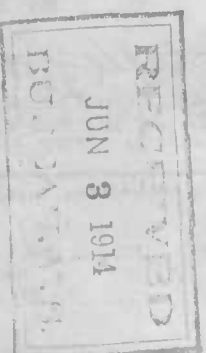
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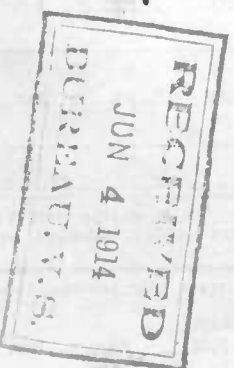
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oma, *Sarcoma*, etc., of _____ (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congestant," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and quality as accidental, suicidal, or homicidal, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

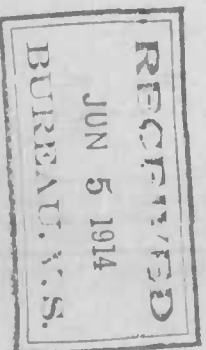
[Approved by U. S. Census and American Public Health Association.]

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Statement of cause of death—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc.. *Carcin-*

oma, *Sarcoma*, etc., of _____ (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.*; *Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Anemia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congential," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "Puerperal septicemia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and qualify as accidental, suicidal, or homicidal, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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1 PLACE OF DEATH 4602

County Balto.

110

STATE OF MARYLAND
CERTIFICATE OF DEATHRegistration Dist. No. 41Village or City Highlandtown (No. 715, S. East Ave. St.; _____ Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME George Deuerling

PERSONAL AND STATISTICAL PARTICULARS

3 SEX M. 4 COLOR OR RACE W. 5 SINGLE, Single
MARRIED,
WIDOWED,
OR DIVORCED
(Write the word)

6 DATE OF BIRTH Oct. 24th, 1912
(Month) (Day) (Year)7 AGE _____ If LESS than
1 day, _____ hrs.
1 yrs. 6 mos. 28 ds. OR min. ?

8 OCCUPATION
(a) Trade, profession, or particular kind of work. Infant
(b) General nature of industry, business, or establishment in which employed (or employer) _____

9 BIRTHPLACE (State or country) Highlandtown Md.10 NAME OF FATHER Frank Deuerling11 BIRTHPLACE OF FATHER (State or country) Germany12 MAIDEN NAME OF MOTHER Margaret Guenther13 BIRTHPLACE OF MOTHER (State or country) Baltimore

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Frank Deuerling(Address) 715 S. East Ave.15 Filed May 22, 1914 W. C. McClanahan

REGISTRAR

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH May 21st, 1914
(Month) (Day) (Year)17 I HEREBY CERTIFY, That I attended deceased from May 21st, 1914, to May 21st, 1914.that I last saw him alive on May 21st, 1914.and that death occurred on the date stated above, at 9 P. M.

The CAUSE OF DEATH* was as follows:

Concussion(Duration) _____ yrs. _____ mos. 7 ds.Contributory Intestinal infection
Secondary(Duration) _____ yrs. _____ mos. 2 ds.(Signed) W. C. McClanahan, M. D.May 12, 1914 (Address) John Deuerling

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds.

Where was disease contracted, If not at place of death? _____

Former or usual residence _____

19 PLACE OF BURIAL OR REMOVAL Holy Redeemer DATE OF BURIAL May 23rd, 191420 UNDERTAKER Wendell Lippel Son ADDRESS 37 S. Ann St.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

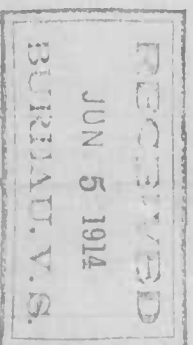
[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not faithfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Former (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcin-*

oma, Sarcoma, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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1 PLACE OF DEATH 4603

County BaltoVillage or City Canton (No. 3612 Willon)Registration Dist. No. 41

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME Acelia Downes

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE white 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED married
(Write the word)

6 DATE OF BIRTH March 30, 1881
(Month) (Day) (Year)

7 AGE 27 yrs. 1 mos. 19 ds. If LESS than 1 day.....hrs. OR.....min. ?

8 OCCUPATION
(a) Trade, profession, or particular kind of work House work
(b) General nature of industry, business, or establishment in which employed (or employer) House wife

9 BIRTHPLACE (State or country) Baltimore Co

10 NAME OF FATHER Henry Brien

11 BIRTHPLACE OF FATHER (State or country) Germany

12 MAIDEN NAME OF MOTHER Not known

13 BIRTHPLACE OF MOTHER (State or country) Germany

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

Informant Charles Brien

(Address) 3612 Willon St.

15 Filed May 20, 1914 W. E. McClanahan

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH May 19, 1914
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from May 5, 1914, to May 19, 1914

that I last saw him alive on May 18, 1914

and that death occurred on the date stated above, at 12 30 P. M.

The CAUSE OF DEATH* was as follows:

Exhaustion
Syncope

(Duration) X yrs. X mos. 1 ds.

Contributory (Secondary) acute Phthisis

(Duration) X yrs. 2 mos. X ds.

(Signed) Jos. L. Cissner, M. D.
May 20, 1914 (Address) 248 So. Third

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, If not at place of death?

Former or usual residence.....

19 PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

St. Carmel Cem May 20, 1914

20 UNDERTAKER ADDRESS

Joseph B. Crook 1013 W. Balt.

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

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Statement of cause of death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc.. *Carcin-*

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RECEIVED

JUN 5 1914

BUREAU, V. S.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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1 PLACE OF DEATH 4604

County BaltimoreVillage or City Catonsville (No. _____)Registration Dist. No. 30

St. _____ Ward _____

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME Sister Mary Euphemia Doyle

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) Single

6 DATE OF BIRTH Unknown, 1884
(Month) (Day) (Year)

7 AGE 80 yrs. _____ mos. _____ ds. If LESS than 1 day, _____ hrs. OR _____ mo. ?

8 OCCUPATION (a) Trade, profession, or particular kind of work Religious
(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE (State or country) Ireland

10 NAME OF FATHER John Doyle
11 BIRTHPLACE OF FATHER (State or country) Ireland
12 MAIDEN NAME OF MOTHER Anastasia Murphy
13 BIRTHPLACE OF MOTHER (State or country) Ireland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mother John Doyle
(Address) 220 N. Baltimore St.

15 Filed May 29, 1914 Marshall B. West
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH May 28, 1914
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from May 25, 1914, to May 28, 1914, that I last saw him alive on May 28, 1914

and that death occurred on the date stated above, at 12:30 p. m.
The CAUSE OF DEATH* was as follows:

Lobar Pneumonia
(Type list)
(Duration) _____ yrs. _____ mos. 4 ds.

Contributory (Secondary)

(Signed) Donald H. McManis, M. D.
May 29, 1914 (Address) Catonsville, Md.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death _____ yrs. _____ mos. _____ ds. to the State _____ yrs. _____ mos. _____ ds.
Where was disease contracted, If not at place of death? _____
Former or usual residence _____

19 PLACE OF BURIAL OR REMOVAL Mount St. Sales DATE OF BURIAL May 29, 1914

20 UNDERTAKER Mar. Le Preux & Son ADDRESS Catonsville

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

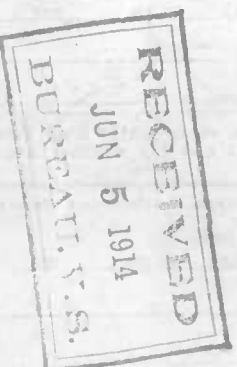
[Approved by U. S. Census and American Public Health Association.]

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Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Group"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcin-*

oma, *Sarcoma*, etc., of _____ (name organ; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.*; *Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Anæmia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congential," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Træmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state MEANS OF INJURY and quality as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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1 PLACE OF DEATH County <u>Balto</u> 4605		STATE OF MARYLAND CERTIFICATE OF DEATH	
Village or City <u>Hamilton</u> (No. _____) St.; _____ Ward)		Registration Dist. No. <u>38</u>	
2 FULL NAME <u>Laura V. Drebing</u>			
PERSONAL AND STATISTICAL PARTICULARS			
3 SEX <u>Female</u>	4 COLOR OR RACE <u>wh</u>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED <u>Married</u> (Write the word)	
6 DATE OF BIRTH <u>Aug 14</u> , 18 <u>74</u> (Month) (Day) (Year)			
7 AGE <u>39</u> yrs. <u>8</u> mos. <u>26</u> ds.		If LESS than 1 day, _____ hrs. OR _____ min. ?	
8 OCCUPATION (a) Trade, profession, or particular kind of work <u>none</u> (b) General nature of industry, business, or establishment in which employed (or employer)			
9 BIRTHPLACE (State or country) <u>Baltimore</u>			
PARENTS	10 NAME OF FATHER <u>Robert E. Burns</u>		
	11 BIRTHPLACE OF FATHER (State or country) <u>Baltimore</u>		
	12 MAIDEN NAME OF MOTHER <u>Georgiana Lee</u>		
	13 BIRTHPLACE OF MOTHER (State or country) <u>Baltimore</u>		
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>Charles H. Drebing</u> (Address) <u>Hamilton</u>			
15 Filed <u>5/11</u> , 191 <u>4</u> <u>C. Claud Smith</u> REGISTRAR			
MEDICAL CERTIFICATE OF DEATH			
16 DATE OF DEATH <u>May 10</u> , 191 <u>4</u> (Month) (Day) (Year)			
17 I HEREBY CERTIFY, That I attended deceased from <u>September 13</u> , 191 <u>3</u> , to <u>May 10</u> , 191 <u>4</u> , that I last saw her alive on <u>May 10</u> , 191 <u>4</u> , and that death occurred on the date stated above, at <u>8:10 P.m.</u> , The CAUSE OF DEATH* was as follows: <u>Chronic Parenchymatous Nephritis</u> <u>Chronic Parenchymatous Nephritis</u> (Duration) <u>1</u> yrs. _____ mos. _____ ds. Contributory Secondary (Duration) <u>1</u> yrs. _____ mos. _____ ds. (Signed) <u>Monis B. Green</u> , M. D. <u>May 11</u> , 191 <u>4</u> (Address) <u>Hamilton Ind</u>			
*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.			
18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS) At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds. Where was disease contracted, If not at place of death? _____ Former or usual residence _____			
19 PLACE OF BURIAL OR REMOVAL <u>Orem M. E. Cemetery</u>		DATE OF BURIAL <u>May 13</u> , 191 <u>4</u>	
20 UNDERTAKER <u>For B. Cook</u>		ADDRESS <u>1003 W. Baltimore</u>	

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not faithfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcin-*

oma, *Sarcoma*, etc., if..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Mars-mus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal, septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, suicidal, or homicidal, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carboic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

RECEIVED

JUN 5 1914

BUREAU, V. S.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH Baltimore
County Baltimore

4606

120

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No. 38

Village or City Hollins (No. _____, St.; _____ Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME Mary Gausse Du Bois,

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE white 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Single
(Write the word)

6 DATE OF BIRTH 11 20, 1832
(Month) (Day) (Year)

7 AGE 82 yrs. 6 mos. 4 ds. If LESS than 1 day, hrs. OR min. ?

8 OCCUPATION (a) Trade, profession, or particular kind of work house
(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE (State or country) Maryland

PARENTS
10 NAME OF FATHER Edmund Du Bois,
11 BIRTHPLACE OF FATHER (State or country) Maryland
12 MAIDEN NAME OF MOTHER Jane Graham,
13 BIRTHPLACE OF MOTHER (State or country) Maryland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) F. M. Du Bois

(Address) 4 Hollins Md.

15 Filed May 25, 1914 M. G. Porlin
Deputy Clerk REGISTRAR

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH 5 24, 1914
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from Feb. 12, 1914, to May 24, 1914.

that I last saw him alive on May 10, 1914.

and that death occurred on the date stated above, at 5.0 m.

The CAUSE OF DEATH* was as follows:

Chronic dilatative nephritis,
Cardiac asthma,
Fractured femur due to fall
(Duration) 10 yrs. ? mos. 15 ds.

Contributory broken hip, bed sores,
Secondary (Duration) 3 yrs. 12 mos. 12 ds.

(Signed) Harry D. McPartly, M. D.
May 24, 1914 (Address) 37 W. Preston

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds.

Where was disease contracted, If not at place of death?

Former or usual residence.

19 PLACE OF BURIAL OR REMOVAL St Thomas German Garrison DATE OF BURIAL May 26, 1914

20 UNDERTAKER W. J. R. Smith & Sons 6 Orchard St.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

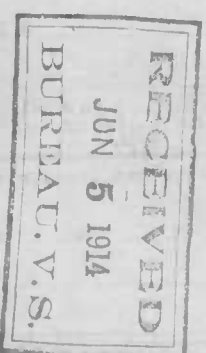
[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcin-*

oma, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asphyxia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congential," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal *septicæmia*," "Puerperal *peritonitis*," etc. State cause for which surgical operation was undertaken. For violent DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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1 PLACE OF DEATH County <u>Balto</u> 4607			(103) STATE OF MARYLAND CERTIFICATE OF DEATH		
Village or City <u>Groves Md</u> (No. <u>502</u> <u>Harwood Ave</u>), Ward			Registration Dist. No. <u>38</u>		
2 FULL NAME <u>Marie Louise Faethe</u>					
PERSONAL AND STATISTICAL PARTICULARS					
3 SEX <u>Female</u>	4 COLOR OR RACE <u>White</u>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED <u>Single</u> (Write the word)			
6 DATE OF BIRTH <u>Nov 9</u> , 18 <u>64</u> (Month) (Day) (Year)		7 AGE <u>49</u> yrs. <u>6</u> mos. <u>14</u> ds. If LESS than 1 day.....hrs. OR.....min.?			
8 OCCUPATION (a) Trade, profession, or particular kind of work <u>artist</u> (b) General nature of industry, business, or establishment in which employed (or employer)					
9 BIRTHPLACE (State or country) <u>Md</u>					
PARENTS	10 NAME OF FATHER <u>Gustfried Faethe</u>				
	11 BIRTHPLACE OF FATHER (State or country) <u>Germany</u>				
	12 MAIDEN NAME OF MOTHER <u>Katharine Reif</u>				
13 BIRTHPLACE OF MOTHER (State or country) <u>Germany</u>					
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>Katharine Faethe</u> (Address) <u>502 Harwood Ave</u>					
15 Filed <u>5/25</u> , 19 <u>14</u> <u>Claud Smith</u> REGISTRAR					
MEDICAL CERTIFICATE OF DEATH					
16 DATE OF DEATH <u>May 23</u> , 19 <u>14</u> (Month) (Day) (Year)					
17 I HEREBY CERTIFY, That I attended deceased from <u>April 1</u> , 19 <u>14</u> , to <u>May 23</u> , 19 <u>14</u> , that I last saw her alive on <u>May 23</u> , 19 <u>14</u> , and that death occurred on the date stated above, at <u>10 P. m.</u> The CAUSE OF DEATH* was as follows: <u>Gastritis</u>					
(Duration) yrs. <u>1</u> mos. <u>23</u> ds.					
Contributory (Secondary) (Duration) yrs. mos. ds.					
(Signed) <u>J. C. H. H. H. H. H.</u> , M. D. <u>May 24</u> , 19 <u>14</u> . (Address) <u>Groves Md.</u>					
*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.					
18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS) At place of death yrs. mos. ds. in the State yrs. mos. ds. Where was disease contracted, if not at place of death? Former or usual residence.....					
19 PLACE OF BURIAL OR REMOVAL <u>Breastman</u>					DATE OF BURIAL <u>May 26</u> , 19 <u>14</u>
20 UNDERTAKER <u>Wm. Cook</u>					ADDRESS <u>5028 York</u>

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

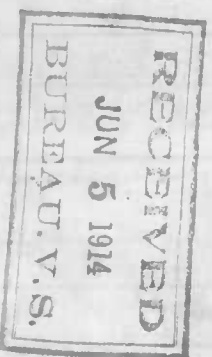
[Approved by U. S. Census and American Public Health Association.]

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Statement of cause of death—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritonæum*, etc. *Carcin-*

oma, *Sarcoma*, etc., of _____ (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asphyxia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such. If impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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1 PLACE OF DEATH

4608

County

Baltimore

92 STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No.

41

Village or City

Highlandtown

(No. 1017 S. Third St.

St.; Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME

Helen M. Fischer

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White

5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word)

Single

6 DATE OF BIRTH

July 8th, 1914

(Month)

(Day)

(Year)

7 AGE

9

25

If LESS than 1 day, hrs.

yrs.

10

mos.

ds.

OR min. ?

8 OCCUPATION

(a) Trade, profession, or particular kind of work

None

(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE

(State or country)

Baltimore Co.

PARENTS

10 NAME OF FATHER

Andrew Fischer

11 BIRTHPLACE OF FATHER (State or country)

Germany

12 MAIDEN NAME OF MOTHER

Magdalena Wichter

13 BIRTHPLACE OF MOTHER (State or country)

Baltimore Co.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Andrew Fischer

(Address)

1017 S. Third St

15

Filed

May 6, 1914 W.E. McClanahan

REGISTRAR

M. D. Kelly & Co. Zeiler

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

May 5th, 1914

(Month)

(Day)

(Year)

17

I HEREBY CERTIFY, That I attended deceased from

June 28, 1914, to

May 5, 1914

that I last saw her alive on

May 4, 1914

and that death occurred on the date stated above, at 9:15 A.M.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(Duration)

yrs.

mos.

ds.

Contributory Secondary

Cerebral

(Duration)

yrs.

mos.

ds.

(Signed)

C. W. A. Hays

M. D.

May 16, 1914

(Address)

100 S. Potomac

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death

yrs.

mos.

ds.

to the State

yrs.

mos.

ds.

Where was disease contracted,

If not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

Sacred Heart Cem.

DATE OF BURIAL

May 7th, 1914

20 UNDERTAKER

ADDRESS

403 S. Wolfest

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

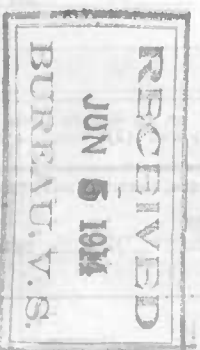
[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coat making*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not faithfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcin-*

oma, Sarcoma, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congestive," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL *septicæmia*," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For violent DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDE, or HOMICIDE, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.



WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PLACE OF DEATH 4609

County BaltimoreVillage or City St. Agnes Hospital (No.)Registration Dist. No. 42St. Ward

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

FULL NAME Miss Alice Fisher

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDDED, OR DIVORCED (Write the word) Single

6 DATE OF BIRTH Sept. 30, 1900
(Month) (Day) (Year)

7 AGE 13 yrs. 7 mos. 26 ds. OR LESS than 1 day, hrs. min. ?

8 OCCUPATION
(a) Trade, profession, or particular kind of work Schoolgirl
(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE (State or country) Balto. Md.

10 NAME OF FATHER John Fisher

11 BIRTHPLACE OF FATHER (State or country) Maryland

12 MAIDEN NAME OF MOTHER Agnes Russell

13 BIRTHPLACE OF MOTHER (State or country) Virginia

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mr. John Fisher(Address) 530 Brunswick St.

15 Filed May 26, 1914 Goodman

REGISTRAR

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

STATE OF MARYLAND
CERTIFICATE OF DEATH

16 DATE OF DEATH May 26, 1914
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from May 11, 1914 to May 26, 1914, that I last saw him alive on May 26, 1914

and that death occurred on the date stated above, at 10:45 a.m., The CAUSE OF DEATH* was as follows:

Metastatic Carcinoma

(Duration) 2 yrs. — mos. — ds.
Contributory Acute Exacerbation of
Secondary Heart

(Duration) ? yrs. — mos. — ds.
(Signed) W. A. Strickland, M. D.
May 26, 1914 (Address) St. Agnes Hospital

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. 12 ds. In the State yrs. mos. ds.
Where was disease contracted, If not at place of death?
Former or usual residence 530 Brunswick St.

19 PLACE OF BURIAL OR REMOVAL Lawson Park DATE OF BURIAL May 29, 1914

20 UNDERTAKER G. A. Gerbig ADDRESS Balto & Mylar

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritonaeum*, etc., *Carcin-*

oma, Sarcoma, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Con-kenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such. If impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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RECEIVED

JUN 4 1914

BUREAU, U. S.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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PLACE OF DEATH		STATE OF MARYLAND	
County		CERTIFICATE OF DEATH	
Village or City		Registration Dist. No.	
4610		42	
Balto Co. Md.		Ward)	
Milkens St. & Primrose Ave.		[If death occurred in a hospital or institution, give its NAME instead of street and number.]	
FULL NAME		Martha A. Flanderoff	
PERSONAL AND STATISTICAL PARTICULARS			
3 SEX	4 COLOR OR RACE	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word)	16 DATE OF DEATH
Female	Wh	Married	May 11, 1914
6 DATE OF BIRTH			17 I HEREBY CERTIFY, That I attended deceased from
Sept 20, 1877			April 27, 1914, to May 11, 1914
(Month) (Day) (Year)			that I last saw her alive on May 11, 1914
7 AGE	If LESS than 1 day, hrs.		and that death occurred on the date stated above, at 11 P. m.
36 yrs. 7 mos. 22 ds.	OR min. ?		The CAUSE OF DEATH* was as follows:
8 OCCUPATION			Septicemia
(a) Trade, profession, or particular kind of work			(Duration) yrs. mos. 5 ds.
Housekeeper.			Contributory
(b) General nature of industry, business, or establishment in which employed (or employer)			Secondary
9 BIRTHPLACE (State or country)			German
Germany			(Duration) yrs. mos. 15 ds.
10 NAME OF FATHER			(Signed) C. Triles, Coroner, M. D.
August Milke			May 11, 1914 (Address) 2129 W. North St.
11 BIRTHPLACE OF FATHER (State or country)			*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
Germany			18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)
12 MAIDEN NAME OF MOTHER			At place of death yrs. mos. ds. In the State yrs. mos. ds.
Matilda Leutz			Where was disease contracted, If not at place of death?
13 BIRTHPLACE OF MOTHER (State or country)			Former or usual residence
Germany			19 PLACE OF BURIAL OR REMOVAL
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE			DATE OF BURIAL
(Informant) Gustav Flanderoff			May 14, 1914
(Address) Milkens St. & Primrose Ave.			20 UNDERTAKER
15 Filed May 13, 1914			Mrs. A. Rohde Fox
REGISTRAR			ADDRESS
			730 Pa Ave

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

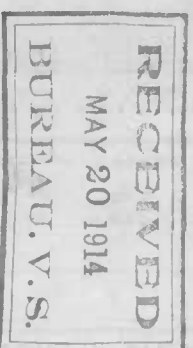
[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the disease causing DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease causing DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meningis, peritonaeum*, etc., *Carcin-*

oma, Sarcoma, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent DEATHS state MEANS OF INJURY and quality as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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4612

1 PLACE OF DEATH
County Balto (152) (CN)

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No. 41

Village or City Highland (No. 200, S St. St. Ward) [If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME Joseph Fortune

PERSONAL AND STATISTICAL PARTICULARS

3 SEX male 4 COLOR OR RACE wh 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED single (Write the word)

6 DATE OF BIRTH unknown (Month) (Day) (Year)

7 AGE 26 yrs. — mos. — ds. If LESS than 1 day, — hrs. — min. ?

8 OCCUPATION (a) Trade, profession, or particular kind of work Laborer (b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE (State or country) Italy

PARENTS

10 NAME OF FATHER unknown

11 BIRTHPLACE OF FATHER (State or country) unknown

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (State or country) unknown

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) _____ (Address) _____

15 May 3, 1914 W. E. McClanahan REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH May 3, 1914 (Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from _____, 191____, to _____, 191____, that I last saw him alive on _____, 191____, and that death occurred on the date stated above, at _____ m. The CAUSE OF DEATH* was as follows:

Revolver wound
Homicide
DOB (Duration) _____ yrs. _____ mos. _____ ds.

Contributory _____ Secondary _____ (Duration) _____ yrs. _____ mos. _____ ds.

(Signed) J. S. Winters, M. D. May 3, 1914 (Address) Corcoran

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS) At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds. Where was disease contracted, If not at place of death? _____ Former or usual residence _____

19 PLACE OF BURIAL OR REMOVAL 2334 Jefferson St DATE OF BURIAL 5/3/14, 191____

20 UNDERTAKER Christian Miller ADDRESS 2334 Jefferson

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

Approved by U. S. Census and American Public Health Association.]

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Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritonaeum*, etc., *Carcin-*

oma, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Con-fenial," "Sennie," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæ-mia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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RECEIVED

JUN 5 1914

U. S. DEPT. OF V. S.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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1 PLACE OF DEATH <i>Baltimore</i>		4613		64		STATE OF MARYLAND CERTIFICATE OF DEATH	
County		Village or City <i>Towson</i>		Mindy Bone <i>Sheppard Hospital</i>		Registration Dist. No. <i>11</i>	
2 FULL NAME <i>Sara E. B. Fowler</i>				St. _____ Ward _____		[If death occurred in a hospital or institution, give its NAME instead of street and number.]	
PERSONAL AND STATISTICAL PARTICULARS							
3 SEX <i>Female</i>	4 COLOR OR RACE <i>White</i>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED <i>Widow</i> (Write the word)					
6 DATE OF BIRTH <i>Sept 26, 1828</i> (Month) (Day) (Year)							
7 AGE <i>85 yrs 7 mos 13 ds</i>		If LESS than 1 day, ____ hrs. OR ____ min. ?					
8 OCCUPATION (a) Trade, profession, or particular kind of work <i>None</i> (b) General nature of industry, business, or establishment in which employed (or employer)							
9 BIRTHPLACE (State or country) <i>Mass.</i>							
PARENTS	10 NAME OF FATHER <i>Richard Colt Cogswell</i>						
	11 BIRTHPLACE OF FATHER (State or country) <i>Mass</i>						
	12 MAIDEN NAME OF MOTHER <i>Lawrence</i>						
	13 BIRTHPLACE OF MOTHER (State or country) <i>Mass</i>						
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <i>Edmond H. Bush</i> (Address) <i>Mindy Bone Towson</i>							
15 Filed <i>May 10, 1914</i> M. G. Porter <i>Deputy Local</i> REGISTRAR							
If more blanks are needed, address State Registrar, 6 N. Franklin St., Balto., Requesting V. S. No. 1.							
MEDICAL CERTIFICATE OF DEATH							
16 DATE OF DEATH <i>May 9, 1914</i> (Month) (Day) (Year)							
17 I HEREBY CERTIFY, That I attended deceased from <i>April 20, 1914</i> , to <i>May 9, 1914</i> , that I last saw her alive on <i>May 9, 1914</i> , and that death occurred on the date stated above, at <i>2:05 P. M.</i> , The CAUSE OF DEATH* was as follows:							
<i>Central Embolism Right Hemiplegia - aphasia (Duration) ____ yrs ____ mos. 20 ds. Contributory Pulmonary Oedema Secondary (Duration) ____ yrs ____ mos. 2 ds. (Signed) G. F. Sargent, M. D. May 9, 1914 (Address) Towson Md.</i>							
*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.							
18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS) At place of death ____ yrs. ____ mos. ____ ds. In the State ____ yrs. ____ mos. ____ ds. Where was disease contracted, if not at place of death? _____ Former or usual residence _____							
19 PLACE OF BURIAL OR REMOVAL <i>Buffalo N.Y.</i> DATE OF BURIAL <i>May 11, 1914</i>							
20 UNDERTAKER <i>J. W. Jenkins & Sons Co</i> ADDRESS <i>Orchard Inc Cullough St</i>							

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

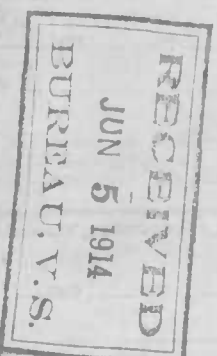
[Approved by U. S. Census and American Public Health Association.]

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Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritonaeum*, etc., *Carcin-*

oma, Sarcoma, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thema," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congential," "Senile" etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH 4614

County BaltoVillage or City Hamilton (No. 3 Maple)STATE OF MARYLAND
CERTIFICATE OF DEATHRegistration Dist. No. 38

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME John A French

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Married
(Write the word)

6 DATE OF BIRTH Aug- 24, 1855
(Month) (Day) (Year)

7 AGE 58 yrs. 9 mos. 22 ds. If LESS than 1 day, hrs. OR min. ?

8 OCCUPATION
(a) Trade, profession, or particular kind of work Salesman
(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE (State or country) Md.

10 NAME OF FATHER Geo W. French

11 BIRTHPLACE OF FATHER (State or country) Md.

12 MAIDEN NAME OF MOTHER Mary Green

13 BIRTHPLACE OF MOTHER (State or country) Md.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Ella Foster French

(Address) # 3 Maple Ave

15 Filed 5/21, 1914 Claud Smith

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH May 19, 1914
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from May 14, 1914, to May 19, 1914.

that I last saw him alive on May 19, 1914.

and that death occurred on the date stated above, at 5 P m.

The CAUSE OF DEATH* was as follows:

Croupous Pneumonia

(Duration) 6 yrs. 2 mos. 17 ds.
Contributory Chr. Intestinal Inflamm.
Secondary

(Signed) Chas. B. Fugate, M. D.
May 20, 1914 (Address) 830 N Broadway

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL London Park DATE OF BURIAL May 23, 1914

20 UNDERTAKER W. H. Tinkler ADDRESS 1000 N. 1st St.

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

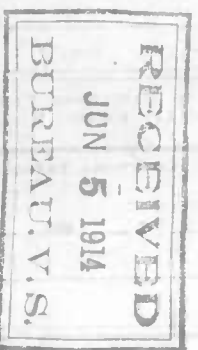
[Approved by U. S. Census and American Public Health Association.]

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Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tubercles of lungs*, *meninges*, *peritoneum*, etc., *Carcin-*

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1 PLACE OF DEATH 4615

County BaltimoreVillage or City Fowblesburg (No. _____)2 FULL NAME Ellen R. FringerSTATE OF MARYLAND
CERTIFICATE OF DEATHRegistration Dist. No. 33

St; _____ Ward _____

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE white 5 ~~SINGLE~~ MARRIED, WIDOWED, ~~SEPARATED~~ widowed
(Write the word)

6 DATE OF BIRTH 10 12 1887
(Month) (Day) (Year)

7 AGE 76 yrs. 6 mos. 22 ds. If LESS than 1 day, _____ hrs. OR _____ min. ?

8 OCCUPATION
(a) Trade, profession, or particular kind of work House wife
(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE (State or country) Md

10 NAME OF FATHER George Baker

11 BIRTHPLACE OF FATHER (State or country) Pa

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (State or country) Unknown

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Oliver M. Fringer(Address) Fowblesburg Md

15 Filed May 5, 1914 Jastt Wilson Md
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH 5 - 4, 1914
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from Same time in, 1912, to May 4, 1914,

that I last saw her alive on May 3^d, 1914

and that death occurred on the date stated above, at 6 A.m.

The CAUSE OF DEATH* was as follows:

Paralysis of Brain

(Duration) _____ yrs. _____ mos. 4 ds.

Contributory (Secondary) Maritis

(Duration) 2 yrs. _____ mos. _____ ds.

(Signed) Jastt Wilson, M. D.

May 5, 1914 (Address) Fowblesburg Md

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds.

Where was disease contracted, If not at place of death? _____

Former or usual residence _____

19 PLACE OF BURIAL OR REMOVAL _____ DATE OF BURIAL _____

St. Paul Cemetery May 4, 1914

20 UNDERTAKER _____ ADDRESS _____

C. V. Leptonson Hampstead

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

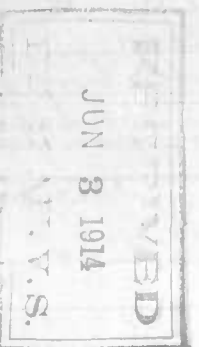
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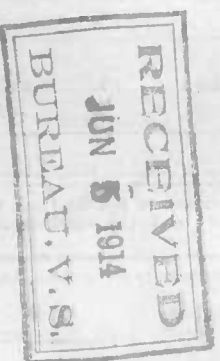
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4617

1 PLACE OF DEATH

County

Village or City

2 FULL NAME

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No.

St.; Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) Married

6 DATE OF BIRTH

March 9th, 1866
(Month) (Day) (Year)

7 AGE

48 yrs. 1 mos. 21 ds. If LESS than 1 day, hrs. OR min. ?

8 OCCUPATION

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

Store and Sewing Attended Post.

9 BIRTHPLACE

(State or country)

Germany

PARENTS

10 NAME OF FATHER

John Gueller

11 BIRTHPLACE OF FATHER (State or country)

Germany

12 MAIDEN NAME OF MOTHER

Anne M. Eichorn

13 BIRTHPLACE OF MOTHER (State or country)

Germany

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Annie M. Gueller

(Address)

Halethorp - Md.

15

Filed

May 1, 1914 F. T. Ruhl

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

May 1, 1914
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from March 20th, 1914, to April 30th, 1914.

that I last saw him alive on April 30th, 1914.

and that death occurred on the date stated above, at 1:30 P.M.

The CAUSE OF DEATH* was as follows:

Atrophic cirrhosis of liver, with ascites

(Duration) yrs. 5 mos. ds.

Contributory Secondary

Alcohol (Duration) yrs. mos. ds.

(Signed) J. M. L. Smith, M.D.

May 1, 1914 (Address) Halethorp - Md.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, If not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Holly Cross and May 4, 1914

20 UNDERTAKER

ADDRESS

J. M. L. Smith 1729 W. Pratt

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

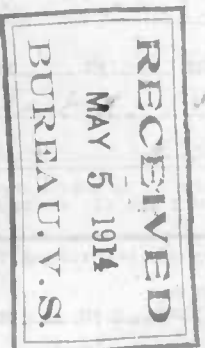
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PLACE OF DEATH

4618

County

Baltimore

 STATE OF MARYLAND
 CERTIFICATE OF DEATH

Registration Dist. No.

41

Village or City

Highlandtown

(No.

703 S. Third St

St.;

Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

FULL NAME

May E. Goldbeck

PERSONAL AND STATISTICAL PARTICULARS

SEX

Female

COLOR OR RACE

White

 SINGLE,
 MARRIED,
 WIDOWED,
 OR DIVORCED
 (Write the word)

Single

DATE OF BIRTH

Jan. 23rd, 1913

AGE

1 yrs. 3 mos. 24 ds.

 If LESS than
 1 day, ____ hrs.
 OR ____ min. ?

OCCUPATION

 (a) Trade, profession, or
 particular kind of work

House

 (b) General nature of industry,
 business, or establishment in
 which employed (or employer)

BIRTHPLACE

(State or country)

Baltimore Co.

PARENTS

NAME OF FATHER

John C. H. Goldbeck

BIRTHPLACE OF FATHER
(State or country)

Baltimore Co.

MAIDEN NAME OF MOTHER

Elizabeth Goldbeck

BIRTHPLACE OF MOTHER
(State or country)

Baltimore City

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

John C. H. Goldbeck

(Address)

703 S. Third St.

FILED

May 8, 1914 W. E. McLaughlin

REGISTRAR

UNDERTAKER

H. S. Siley & Co. Ziehl

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH

May 7th, 1914
 I HEREBY CERTIFY, That I attended deceased from
 April 30, 1914 to May 7, 1914

that I last saw her alive on May 7, 1914

and that death occurred on the date stated above, at 12:20 A. M.

The CAUSE OF DEATH* was as follows:

Broncho. Pneumonia

Contributory
Secondary

(Duration) ____ yrs. ____ mos. ____ ds.

(Duration) ____ yrs. ____ mos. ____ ds.

(Signed)

Dr. John S. Owens, M. D.

May 7, 1914 (Address) Paramount Hotel Baltimore

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ____ yrs. ____ mos. ____ ds. In the State ____ yrs. ____ mos. ____ ds.

 Where was disease contracted,
 if not at place of death?

 Former or
 usual residence

PLACE OF BURIAL OR REMOVAL

Holy Redeemer

DATE OF BURIAL

May 7, 1914

ADDRESS

403 S. W. 100th

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mining*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At Home*, and children, not gainfully employed, as *At school or At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcin-*

oma, Sarcoma, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic tubular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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RECEIVED
JUN 5 1914
BUREAU, V. S.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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1 PLACE OF DEATH 4619

County BaltimoreVillage or City Mr Minus (No. 78)Registration Dist. No. 42

St.; Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME Mr August Grewe

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 SINGLE, Single
~~MARRIED,~~
~~WIDOWED,~~
~~DIVORCED~~
 (Write the word)

6 DATE OF BIRTH 3 8, 1903
 (Month) (Day) (Year)

7 AGE 11 yrs. 2 mos. 23 ds. It LESS than
 1 day, hrs. OR min. ?

8 OCCUPATION
 (a) Trade, profession, or particular kind of work none
 (b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE (State or country) New Port News Va.

PARENTS
 10 NAME OF FATHER Eustace J. Grewe
 11 BIRTHPLACE OF FATHER (State or country) Germany
 12 MAIDEN NAME OF MOTHER Christina Allmann
 13 BIRTHPLACE OF MOTHER (State or country) Germany

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
 (Informant) Guertar J. Grewe
 (Address) 2111 Weymouth Md.

15 Filed June 1, 1914 J. F. A. Ruhl
 REGISTRAR

STATE OF MARYLAND
CERTIFICATE OF DEATH

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH 5 31, 1914
 (Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from May 1, 1914, to May 31, 1914.

that I last saw him alive on May 31, 1914

and that death occurred on the date stated above, at 2-5 P. m.

The CAUSE OF DEATH* was as follows:

Valvular Heart disease
+ Tuberculosis

(Duration) 1 yrs. 6 mos. 6 ds.
 Contributory Exhaustion
 Secondary

(Duration) 1 yrs. 6 mos. 6 ds.
 (Signed) T. B. Hall, M. D.

May 31, 1914 (Address) Mr Minus

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death 1 yrs. 6 mos. 6 ds. In the State 1 yrs. 6 mos. 6 ds.

Where was disease contracted, If not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL Western Cemetery DATE OF BURIAL June 3, 1914

20 UNDERTAKER N. S. Fink ADDRESS 1924 N. Bass

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

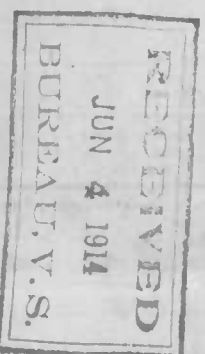
[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not faithfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritonaeum*, etc., *Carcin-*

oma, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septichæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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1 PLACE OF DEATH 4620
 County Baltimore
 Village or City Catonsville (No. Open Ward St. 1st)
 2 FULL NAME Laura V. Griffith

STATE OF MARYLAND
 CERTIFICATE OF DEATH
 Registration Dist. No. 20

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Fe 4 COLOR OR RACE white 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Married
 (Write the word)

6 DATE OF BIRTH Jan 15th, 1847
 (Month) (Day) (Year)

7 AGE 67 yrs. 4 mos. 15 ds. If LESS than 1 day, hrs. OR min. ?

8 OCCUPATION
 (a) Trade, profession, or particular kind of work None
 (b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE (State or country) Maryland

10 NAME OF FATHER William Sweitzer

11 BIRTHPLACE OF FATHER (State or country) Maryland

12 MAIDEN NAME OF MOTHER unk.

13 BIRTHPLACE OF MOTHER (State or country) unk.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Wm A. Buffett
 (Address) 2815 N. North Ave

15 Filed May 31, 1914 Marshall B Wrost
 REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH May 30th, 1914
 (Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from Aug 27th, 1909 to May 30th, 1914
 that I last saw her alive on May 30th, 1914

and that death occurred on the date stated above, at 10 30 P. m.
 The CAUSE OF DEATH* was as follows:

Facial Erysipelas
 (Duration) yrs. mos. 3 ds.

Contributory Scrub Scurvy
 Secondary (Duration) yrs. mos. ds.

(Signed) Percy Wade, M. D.
May 31st, 1914 (Address) Catonsville Md

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death 4 yrs. 8 mos. 3 ds. In the State yrs. mos. ds.

Where was disease contracted, If not at place of death?
 Former or usual residence Balti. Md

19 PLACE OF BURIAL OR REMOVAL Landon Park Cemetery DATE OF BURIAL June 2, 1914

20 UNDERTAKER Gilbur W. Shriver ADDRESS 316 Fremont Ave

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

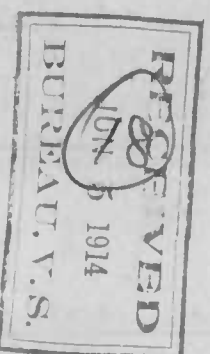
[Approved by U. S. Census and American Public Health Association.]

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Statement of cause of death—Name, first, the DISEASE CAUSING DEATH (the primary affection, with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcin-*

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¹ PLACE OF DEATH *462 pnothet certy.*
County *Baltimore*

STATE OF MARYLAND CERTIFICATE OF DEATH

Registration Dist. No. *4-1*

Village or City *Highlandtown* (No. *704, S. 3rd St*) St.; Ward) [If death occurred in a hospital or institution, give its NAME instead of street and number.]

² FULL NAME *Still Born (Twin) Gunther*

PERSONAL AND STATISTICAL PARTICULARS

³ SEX *Male* ⁴ COLOR OR RACE *White* ⁵ SINGLE, MARRIED, WIDOWED, OR DIVORCED *Single*
(Write the word)

⁶ DATE OF BIRTH *May 3rd, 1914*
(Month) (Day) (Year)

⁷ AGE _____ yrs. _____ mos. _____ ds. *If LESS than 1 day, _____ hrs. OR _____ mo. ?*

⁸ OCCUPATION
(a) Trade, profession, or particular kind of work *None*
(b) General nature of industry, business, or establishment in which employed (or employer)

⁹ BIRTHPLACE (State or country) *Baltimore, Md.*

¹⁰ NAME OF FATHER *Fredrick H. Gunther*

¹¹ BIRTHPLACE OF FATHER (State or country) *Baltimore City*

¹² MAIDEN NAME OF MOTHER *Bertha Dittmar*

¹³ BIRTHPLACE OF MOTHER (State or country) *Baltimore Co.*

¹⁴ THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) *Fredrick H. Gunther*

(Address) *704 S. 3rd St*

¹⁵ FILE *May 4, 1914* *W. C. McLaughlin*

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

¹⁶ DATE OF DEATH *May 3rd, 1914*
(Month) (Day) (Year)

¹⁷ I HEREBY CERTIFY, That I attended deceased from *May 3*, 1914, to _____, 1914.

that I last saw him _____ alive on _____, 1914.

and that death occurred on the date stated above, at *3 P.* m.

The CAUSE OF DEATH* was as follows:

Still born - 4th - 5th month - gestation
(Duration) _____ yrs. _____ mos. _____ ds.

Contributory _____
Secondary _____

(Signed) *James B. Brown*, M. D.
May 4, 1914. (Address) *125 S. Broadway*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, OR HOMICIDAL.

¹⁸ LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds.

Where was disease contracted, if not at place of death?

Former or usual residence _____

¹⁹ PLACE OF BURIAL OR REMOVAL *Oak Lawn Cem.* DATE OF BURIAL *May 4th, 1914*

²⁰ UNDERTAKER *Lily W. Ziehl* ADDRESS *403 S. Wolfe St.*

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

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Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritonaeum*, etc., *Carcinoma*, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic tubular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congestant," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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RECEIVED
JUN 5 1914
HARRIS, V. S.

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1 PLACE OF DEATH 4622

County

Balto

Village or City

balgate

(No.

4th Ave + 19th St.

Registration Dist. No.

41

St.; Ward

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME

Henry Haas

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 SINGLE,

MARRIED,

WIDDED,

OR DIVORCED

(Write the word)

Married

6 DATE OF BIRTH

Sept 11th, 1874

(Month)

(Day)

(Year)

7 AGE

39 yrs.

7 mos.

27 ds.

If LESS than

1 day, hrs.

OR min. ?

8 OCCUPATION

(a) Trade, profession, or particular kind of work

Farmer

(b) General nature of industry, business, or establishment in which employed (or employer)

Farmer.

9 BIRTHPLACE

(State or country)

Md

10 NAME OF FATHER

Geo Haas

11 BIRTHPLACE OF FATHER (State or country)

Germany

12 MAIDEN NAME OF MOTHER

Friederike Not Known

13 BIRTHPLACE OF MOTHER (State or country)

Md

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

Informant

Margaret Haas

(Address)

4th Ave + 19th St.

15

Filed

May 8, 1914 W. E. McLaughlin

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

May 7, 1914

(Month)

(Day)

(Year)

17 I HEREBY CERTIFY, That I attended deceased from March 2, 1914, to May 7, 1914,

that I last saw him alive on May 7, 1914,

and that death occurred on the date stated above, at 8:45 P. M.

The CAUSE OF DEATH* was as follows:

Coma + Exhaustion

Contributory (Secondary)

(Duration) 4 yrs. 8 mos. 7 ds.

Pulmonary Tuberculosis

(Duration) 4 yrs. 5 mos. 4 ds.

(Signed)

Jas. L. P. Marx M. D.

May 8, 1914 (Address) 248 S. 9th St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, If not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

Mt Carmel

DATE OF BURIAL

May 10, 1914

20 UNDERTAKER

Philip Herwig

ADDRESS

2016 Orleans

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. 5. No. 1.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

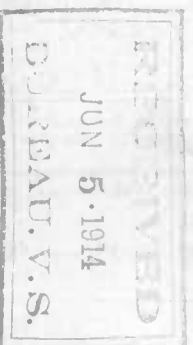
[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Form laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritonaeum*, etc., *Carcin-*

oma, *Sarcoma*, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.*; *Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congential," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Insanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "Puerperal septichæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such. If impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.



WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH 4623
 County Baltimore
 Village or City W. Roland Park (No. 222 Falls Road) St. 10.9 Ward 18
 Registered No. 18

2 FULL NAME Sydney Hall

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE C 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED widow
 (Write the word)

6 DATE OF BIRTH Not Known
 (Month) (Day) (Year)

7 AGE About 60 yrs. mos. ds. It LESS than 1 day, hrs. OR min. ?

8 OCCUPATION
 (a) Trade, profession, or particular kind of work None
 (b) General nature of industry, business, or establishment in which employed (or employer) C

9 BIRTHPLACE (State or country) Virginia

10 NAME OF FATHER Not Known

11 BIRTHPLACE OF FATHER (State or country) Not Known

12 MAIDEN NAME OF MOTHER Not Known

13 BIRTHPLACE OF MOTHER (State or country) Not Known

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
 (Informant) Rebecca Sheppard

(Address) 315 Falls Rd.

15 Filed May 11, 1914 M. J. Fortin
 REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH May-10, 1914
 (Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from May 3, 1914, to May 10, 1914.

that I last saw her alive on May 10, 1914.

and that death occurred on the date stated above, at 11:30 a. m.

The CAUSE OF DEATH* was as follows:

Acute hemorrhagic repeated attacks producing Bright's Disease (Duration) yrs. 6 mos. ds.

Contributory (Secondary) Agues Exposure

(Signed) Edward Short, M. D.

May 18, 1914 (Address) 1812 Druid Hill Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, If not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Mt Auburn 5/12, 1914

20 UNDERTAKER ADDRESS

Sam L. L. L. L. 598 H. Bide

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

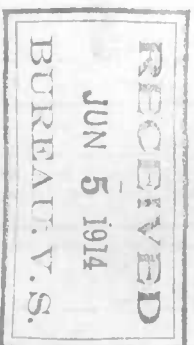
[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Cool mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not faithfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc.. *Carcin-*

oma, *Sarcoma*, etc., of _____ (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Anæmia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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1 PLACE OF DEATH

County Baltimore Co.Village or City Notch Cliff

(No.)

St.; Ward)

Registration Dist. No. 38

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME Sister Mary Placida Stodmeyer

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White

5 SINGLE,

MARRIED,

WIDOWED,

OR DIVORCED

(Write the word) Single

6 DATE OF BIRTH

January 27, 1849
(Month) (Day) (Year)

7 AGE

65 yrs. 4 mos. — ds. If LESS than 1 day, hrs. OR min. ?

8 OCCUPATION

(a) Trade, profession, or particular kind of work. Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE (State or country)

Richmond, Va.

PARENTS

10 NAME OF FATHER

Joseph Stodmeyer

11 BIRTHPLACE OF FATHER (State or country)

Europe

12 MAIDEN NAME OF MOTHER

Eliz. Schuellenburg

13 BIRTHPLACE OF MOTHER (State or country)

Europe

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Dr. John S. Green(Address) Gillings, Md.

15

Filed May 3, 1914 C. Claud Smith

REGISTRAR

STATE OF MARYLAND
CERTIFICATE OF DEATH

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

May 27, 1914
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from

Dec. 24, 1913, to May 19, 1914.that I last saw h. es. alive on May 19, 1914and that death occurred on the date stated above, at 3.20 A.M.

The CAUSE OF DEATH* was as follows:

Cancer of liverabout (Duration) 1 yrs. mos. ds.Contributory
Secondary

(Duration) yrs. mos. ds.

(Signed) Dr. John S. Green, M. D.May 27, 1914. (Address) Gillings, Md.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, If not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Notch Cliff (Private) May 22, 1914

20 UNDERTAKER

ADDRESS

A. Pink & Son 915 W. Gay

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritonaeum*, etc., *Carcin-*

oma, Sarcoma, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Træmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal, septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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RECEIVED
JUN 5 1914
BUREAU, V. S.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH 4624

County Baltimore

Village or City Catonville (No. _____, _____ St.; _____ Ward)

2 FULL NAME

Joseph Michael Heagerty

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registered No. 30

[If death occurred in a hospital or institution, give his NAME instead of street and number.]

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Married
(Write the word)

6 DATE OF BIRTH Unknown, 1876
(Month) (Day) (Year)

7 AGE 38 yrs. _____ mos. _____ ds. If LESS than 1 day, _____ hrs. OR _____ min. ?

8 OCCUPATION
(a) Trade, profession, or particular kind of work Veteran Engineer
(b) General nature of industry, business, or establishment in which employed (or employer) _____

9 BIRTHPLACE (State or country) Baltimore

PARENTS
10 NAME OF FATHER Michael Heagerty
11 BIRTHPLACE OF FATHER (State or country) Ireland
12 MAIDEN NAME OF MOTHER Eileen Dunn
13 BIRTHPLACE OF MOTHER (State or country) Ireland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) N. A. K. Heagerty
(Address) 104 N. Fulton St. Balt.

15 Filed May 23, 1914 Marshall B. West
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH May 23, 1914
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from May 8, 1914, to May 23, 1914, that I last saw him alive on May 23, 1914.

and that death occurred on the date stated above, at 11 P. m.
The CAUSE OF DEATH* was as follows:

Exhaustion from exertion
March 23, 1914
General paralysis of the brain
(Duration) _____ yrs. _____ mos. 30 ds.

Contributory (Secondary) _____
(Signed) John J. [unclear], M. D.
(Address) Catonville

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS) Michael Heagerty, [unclear]
At place of death _____ yrs. _____ mos. _____ ds. In the _____ State _____ yrs. _____ mos. _____ ds.
Where was disease contracted, If not at place of death? _____
Former or usual residence Baltimore Md

19 PLACE OF BURIAL OR REMOVAL New Cathedral DATE OF BURIAL May 25, 1914
20 UNDERTAKER E. M. Mitchell ADDRESS 120 W. Fayette

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationery fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*, (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not faintly employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritonaeum*, etc.. *Carcin-*

oma, *Sarcoma*, etc., of _____ (name organ; "Ovarian" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.*; *Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congestial," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "Puerperal septicemia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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RECEIVED

JUN 5 1914

BUREAU, U. V. S.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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1 PLACE OF DEATH 4625

County BaltoVillage or City Lanhamville (No. Beechwood St.; Ward)STATE OF MARYLAND
CERTIFICATE OF DEATHRegistration Dist. No. 43

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME Le Bonace Hess

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE white 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Single
(Write the word)6 DATE OF BIRTH July 29, 1892
(Month) (Day) (Year)7 AGE 21 yrs. 8 mos. 20 ds. It LESS than 1 day, hrs. OR min. ?8 OCCUPATION
(a) Trade, profession, or particular kind of work Clerk
(b) General nature of industry, business, or establishment in which employed (or employer)9 BIRTHPLACE (State or country) Balto. Md.10 NAME OF FATHER Charles T. Hess11 BIRTHPLACE OF FATHER (State or country) Wash. D. C.12 MAIDEN NAME OF MOTHER Mary E. Green13 BIRTHPLACE OF MOTHER (State or country) Balto. Md.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mary E. Hess(Address) Lanhamville Md.15 Filed May 19, 1914 W. H. Cherry REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH May 18, 1914
(Month) (Day) (Year)17 I HEREBY CERTIFY That I attended deceased from May 14, 1914 to May 18, 1914that I last saw him alive on May 18, 1914and that death occurred on the date stated above, at 2:55 a.m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis
(Duration) — yrs. 10 mos. — ds.Contributory (Secondary) Pulmonary Tuberculosis
(Duration) — yrs. 10 mos. — ds.(Signed) Morris B. Green, M. D.
May 18, 1914 (Address) Hamilton Balto. Co.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death — yrs. — mos. — ds. In the State — yrs. — mos. — ds.

Where was disease contracted, If not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

New Cathedral May 22, 1914

20 UNDERTAKER ADDRESS

Wm. Cook 603 E. 7th

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

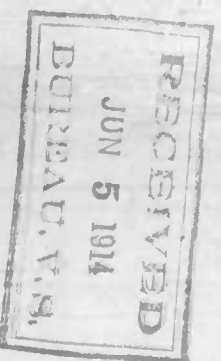
[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Composer*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry; and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mining*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Group"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcin-*

oma, *Sarcoma*, etc., of _____ (name origin: "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Traema," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "Puerperal septicemia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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1 PLACE OF DEATH

4626

County

Balto

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No.

41

Village or City

Canton

(No.)

904 S. First

St.;

Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME

William Elmer Hill

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word)

Single

6 DATE OF BIRTH

Dec 3rd

(Month)

(Day)

1913 (Year)

7 AGE

3 yrs. 5 mos. 11 ds.

If LESS than 1 day, hrs. OR min. ?

8 OCCUPATION

(a) Trade, profession, or particular kind of work

None

(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE

(State or country)

Maryland

PARENTS

10 NAME OF FATHER

Andrew Hill

11 BIRTHPLACE OF FATHER (State or country)

Maryland

12 MAIDEN NAME OF MOTHER

Johanna Friese

13 BIRTHPLACE OF MOTHER (State or country)

Maryland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Johanna Hill

(Address)

904 S. First St

15

Filed

May 15th 1914

W. E. McCauley

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

May 13

(Month)

(Day)

(Year)

17

I HEREBY CERTIFY, That I attended deceased from

May 3

191

to

191

that I last saw him alive on

May 3

191

and that death occurred on the date stated above, at

3:50 P.M.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

(Duration)

yrs.

mos.

10 ds.

Contributory Secondary

Toxemia

(Duration)

yrs.

mos.

1 ds.

(Signed)

M. J. McAvoy

M. D.

May 13, 1914

(Address)

839 S. Ellwood

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place

of death

yrs.

mos.

ds.

In the

State

yrs.

mos.

Where was disease contracted,

If not at place of death?

Former or

usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

St. Evangelical

May 15, 1914

20 UNDERTAKER

ADDRESS

H. Sander Sons

1710 Rea St.

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

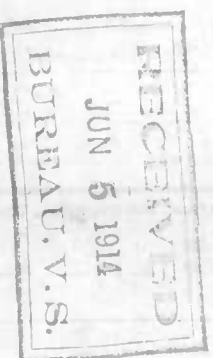
[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritonaeum*, etc., *Carcin-*

oma, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Traemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal *septicæmia*," "Puerperal *peritonitis*," etc. State cause for which surgical operation was undertaken. For violent DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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1 PLACE OF DEATH 4627
County Baltimore

Village or City Sunnybrook (No. _____, St.; _____ Ward)

2 FULL NAME Loretta Caroline Binder

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No. 10

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDDED, OR DIVORCED Single
(Write the word)

6 DATE OF BIRTH March 7, 1897
(Month) (Day) (Year)

7 AGE 17 yrs. 2 mos. 26 ds. If LESS than 1 day, ____ hrs. OR ____ min. ?

8 OCCUPATION (a) Trade, profession, or particular kind of work At home
(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE (State or country) Balto. Co. Md.

PARENTS
10 NAME OF FATHER Fielding Binder
11 BIRTHPLACE OF FATHER (State or country) Balto. Co. Md.
12 MAIDEN NAME OF MOTHER Caroline Schmidt
13 BIRTHPLACE OF MOTHER (State or country) Balto. Co. Md.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Carrie B. Davies
(Address) Sunnybrook, Md.

15 Filed _____, 1914

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH May 31st, 1914
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from January, 1913, to May 31st, 1914
that I last saw her alive on May 31st, 1914

and that death occurred on the date stated above, at 4:30 P.M.
The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(Duration) 1 yrs. 5 mos. ds.

Contributory (Secondary)

(Duration) ____ yrs. ____ mos. ____ ds.

(Signed) J. J. Payne, M. D.
June 1st 1914 (Address) Phoenicia, Md.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ____ yrs. ____ mos. ____ ds. In the State ____ yrs. ____ mos. ____ ds.

Where was disease contracted, If not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL St. Johns Cem. Long Green Md. DATE OF BURIAL June 3rd, 1914

20 UNDERTAKER Slade Bros. ADDRESS Long Green Md.

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

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Statement of cause of death—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc.. *Carcin-*

oma, *Sarcoma*, etc., of _____ (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.*; *Bronchopneumonia* (secondary). *10 ds.* Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congential," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "Puerperal septicaemia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and qualify as ACCIDENTAL, suicidal, or homicidal, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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1 PLACE OF DEATH			STATE OF MARYLAND	
County <u>Baltimore</u>			CERTIFICATE OF DEATH	
Village or City <u>Roland Park</u> (No. <u>325</u> , <u>Roland Ave</u>)			Registered No. <u>38</u>	[If death occurred in a hospital or institution, give its NAME instead of street and number.]
2 FULL NAME <u>Frances Elizabeth Hoew</u>				
PERSONAL AND STATISTICAL PARTICULARS				
3 SEX <u>Female</u>	4 COLOR OR RACE <u>White</u>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED <u>Widow</u> (Write the word)		
6 DATE OF BIRTH <u>November 19</u> , 18 <u>33</u> (Month) (Day) (Year)				
7 AGE <u>80</u> yrs. <u>6</u> mos. <u>5</u> ds.		IF LESS than 1 day, ____ hrs. OR ____ min. ?		
8 OCCUPATION (a) Trade, profession, or particular kind of work. <u>House keep'g</u> (b) General nature of industry, business, or establishment in which employed (or employer)				
9 BIRTHPLACE (State or country) <u>Baltimore Md</u>				
PARENTS	10 NAME OF FATHER <u>Tobias Wisdorff</u>			
	11 BIRTHPLACE OF FATHER (State or country) <u>Maryland</u>			
	12 MAIDEN NAME OF MOTHER <u>Angelie Bisler</u>			
13 BIRTHPLACE OF MOTHER (State or country) <u>Baltimore Md</u>				
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE Informant, <u>Harry Adloew (son)</u> (Address) <u>644 Gorsuch Ave, Baltimore</u>				
15 Filed <u>May 25</u> , 191 <u>4</u> <u>M. G. Porlin</u> <u>Deputy Social</u> REGISTRAR				
MEDICAL CERTIFICATE OF DEATH				
16 DATE OF DEATH <u>May 24</u> , 191 <u>4</u> (Month) (Day) (Year)				
17 I HEREBY CERTIFY, That I attended deceased from <u>May 24</u> , 191 <u>4</u> , to <u>May 24</u> , 191 <u>4</u> , that I last saw her alive on <u>May 24</u> , 191 <u>4</u> , and that death occurred on the date stated above, at <u>11-45 P.m.</u> , The CAUSE OF DEATH* was as follows: <u>Apoplexy</u> (Duration) ____ yrs. ____ mos. ____ ds. Contributory (Secondary) ____ (Duration) ____ yrs. ____ mos. ____ ds. (Signed) <u>W. W. Pearce</u> , M. D. <u>May 25</u> , 191 <u>4</u> . (Address) <u>1238 Summit Ave, Baltimore Md</u> *State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.				
18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS) At place of death ____ yrs. ____ mos. ____ ds. to the State ____ yrs. ____ mos. ____ ds. Where was disease contracted, If not at place of death? Former or usual residence ____				
19 PLACE OF BURIAL OR REMOVAL <u>Green Mt Cemetery</u>			DATE OF BURIAL <u>May 27</u> , 191 <u>4</u>	
20 UNDERTAKER <u>Stewart & Mowen</u>			ADDRESS <u>6215 Park Ave</u>	

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

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Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc. *Carcin-*

oma, *Sarcoma*, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 *ds.*; *Bronchopneumonia* (secondary), 10 *ds.* Never report mere symptoms or terminal conditions, such as "Anemia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congential," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Insanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "Puerperal septicemia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state MEANS OF INJURY and qualify as ACCIDENTAL, suicidal, or homicidal, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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RECEIVED

JUN 5 1914

BUREAU, V. S.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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1 PLACE OF DEATH 4629
 County Baltimore
 Village or City Bare Hill (No. Prim's Road St.; Ward)
 Registered No. 32
 2 FULL NAME Eva J. Hook
 [If death occurred in a hospital or institution, give its NAME instead of street and number.]

PERSONAL AND STATISTICAL PARTICULARS

3 SEX <u>Female</u>	4 COLOR OR RACE <u>white</u>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) <u>Married</u>
6 DATE OF BIRTH <u>Aug 6</u> , 18 <u>48</u> (Month) (Day) (Year)		
7 AGE <u>65</u> yrs. <u>8</u> mos. <u>27</u> ds.		It LESS than 1 day, hrs. OR min. ?
8 OCCUPATION (a) Trade, profession, or particular kind of work..... (b) General nature of industry, business, or establishment in which employed (or employer)..... <u>Housewife</u>		
9 BIRTHPLACE (State or country) <u>Maryland</u>		
PARENTS	10 NAME OF FATHER <u>John Doxson</u>	
	11 BIRTHPLACE OF FATHER (State or country) <u>Penna.</u>	
	12 MAIDEN NAME OF MOTHER <u>Catherine Doxson</u>	
	13 BIRTHPLACE OF MOTHER (State or country) <u>Penna.</u>	

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant).....

(Address).....

15

Filed.....

5/3/14, 1914 Henry G. Taylor
 REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH May 3rd, 1914
 (Month) (Day) (Year)

17 I HEREBY CERTIFY That I attended deceased from
May 2, 191....., to May 3, 191.....
 that I last saw h..... alive on May 3, 191.....
 and that death occurred on the date stated above, at 8:30 p. m.
 The CAUSE OF DEATH* was as follows:
Bright's Disease of
Heart
 (Duration) 1 yrs. 6 mos. ds.
 Contributory (Secondary) Valvular disease of
Heart (Duration) 6 yrs. mos. ds.
 (Signed) W. D. Cooper, M. D.
5/4/14, 191..... (Address) Arlington

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. in the State yrs. mos. ds.

Where was disease contracted,
 if not at place of death?

Former or
 usual residence.....

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Druid Ridge May 6, 1914

20 UNDERTAKER

ADDRESS

Grace Burgeson 3631 Falls Road

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balt., Requesting V. S. No. 1.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

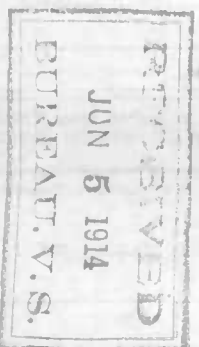
[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The statement "Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not faintly employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc.. *Carcin-*

oma, *Sarcoma*, etc., of (name origin: "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Athetosis," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congential," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Stræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means or injury and quality as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.



WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH 4630

County Baltimore

(119)

STATE OF MARYLAND CERTIFICATE OF DEATH

Registration Dist. No. 40
 Village or City Rear Baldwin (No. _____, _____ St.; _____ Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME James Hooper

PERSONAL AND STATISTICAL PARTICULARS

 3 SEX Male 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDDED, OR DIVORCED Widowed
(Write the word)

 6 DATE OF BIRTH Dec. 13, 1832
(Month) (Day) (Year)

 7 AGE 81 yrs. 4 mos. 20 ds. 1f LESS than 1 day, _____ hrs. OR _____ min. ?

 8 OCCUPATION
(a) Trade, profession, or particular kind of work Farmer
(b) General nature of industry, business, or establishment in which employed (or employer) _____
9 BIRTHPLACE (State or country) Maryland10 NAME OF FATHER John Hooper11 BIRTHPLACE OF FATHER (State or country) Maryland12 MAIDEN NAME OF MOTHER Nancy Schultz13 BIRTHPLACE OF MOTHER (State or country) Maryland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Ella Durham(Address) Baldwin R. D. Md.15 Filed May 4, 1914 L. F. H. Gossman

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

 16 DATE OF DEATH May 3rd, 1914
(Month) (Day) (Year)

 17 I HEREBY CERTIFY, That I attended deceased from May 2, 1914 to May 3, 1914,
that I last saw him alive on May 2, 1914.and that death occurred on the date stated above, at 6 a. m.

The CAUSE OF DEATH* was as follows:

Acute nephritis(Duration) _____ yrs. _____ mos. 2 ds.Contributory Cold
Secondary _____

(Duration) _____ yrs. _____ mos. _____ ds.

 (Signed) John S. Green, M. D.
May 4, 1914 (Address) John S. Green

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds.

Where was disease contracted, If not at place of death? _____

Former or usual residence _____

19 PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Chestnut Grove Cemetery May 5th, 1914

20 UNDERTAKER ADDRESS

Slade Bros. Loony Green

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

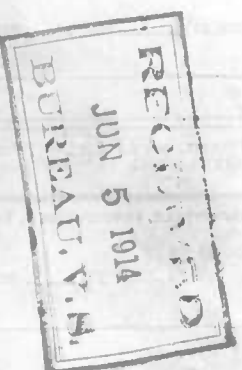
[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritonaeum*, etc., *Carcin-*

oma, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL *septicæmia*," "PUERPERAL *peritonitis*," etc., State cause for which surgical operation was undertaken. For violent DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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1 PLACE OF DEATH 4631

County Balto.Village or City St. Dennis

(No.)

St;

Ward)

Registered No. 42

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME (Still Born) - Hope

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male4 COLOR OR RACE White5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) Single6 DATE OF BIRTH Still Born

(Month)

(Day)

(Year)

7 AGE

If LESS than

1 day, hrs.

yrs.

mos.

ds.

OR min. ?

8 OCCUPATION

(a) Trade, profession, or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE (State or country) Ind.

PARENTS

10 NAME OF FATHER Daniel Hope11 BIRTHPLACE OF FATHER (State or country) Ind.12 MAIDEN NAME OF MOTHER Dorance Baker13 BIRTHPLACE OF MOTHER (State or country) Ind.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Dorance Hope(Address) St. Dennis

15

Filed May 22, 1914F. J. Ruhl

REGISTRAR

STATE OF MARYLAND
CERTIFICATE OF DEATH

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH May 19th, 1914

(Month)

(Day)

(Year)

17 I HEREBY CERTIFY, That I attended deceased from

, 191...., to

, 191....

that I last saw him alive on

, 191....

and that death occurred on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Still Born Infant

Contributory (Secondary)

Health

(Duration)

yrs.

mos.

ds.

(Signed) W. H. P. Dexter

(Duration)

yrs.

mos.

ds.

, M. D.

May 20, 1914(Address) Halethorp - Md

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place

of death yrs.

mos.

ds.

In the

State yrs.

mos.

ds.

Where was disease contracted,

if not at place of death?

Former or

usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Johns Hopkins UniversityMay 19, 1914

20 UNDERTAKER

ADDRESS

Dr. Franklin P. MallJohns Hopkins Hospital

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mining*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not faithfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritonaeum*, etc. *Carcin-*

oma, *Sarcoma*, etc., of _____ (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.*; *Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congential," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Thaniton," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For violent DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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RECEIVED

JUN 4 1914

BUREAU, U. S.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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1 PLACE OF DEATH

4632

County

Baltimore

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No. 30

Village or City

Catonville Spring Enoch Street

(No.)

St.

Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME

Berthe Hopkuis

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Fe

4 COLOR OR RACE

white

5 SINGLE, MARRIED, WIDDED, OR DIVORCED (Write the word)

Maidowed

6 DATE OF BIRTH

March 30th, 1867

(Month)

(Day)

(Year)

7 AGE

47 yrs. 2 mos. 20 ds.

If LESS than 1 day, hrs.

OR min. ?

8 OCCUPATION

(a) Trade, profession, or particular kind of work.

None

(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE (State or country)

Maryland

PARENTS

10 NAME OF FATHER

Wm. J. Murray

11 BIRTHPLACE OF FATHER (State or country)

Maryland

12 MAIDEN NAME OF MOTHER

Mary J. Anderson

13 BIRTHPLACE OF MOTHER (State or country)

Maryland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Cecilia Murray

(Address)

222 N. Calvert St.

15

Filed

May 20, 1914 Marshall B. West

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

May 20th, 1914

(Month)

(Day)

(Year)

17 I HEREBY CERTIFY, That I attended deceased from

June 8, 1912, to May 20th, 1914that I last saw him alive on May 19th, 1914

and that death occurred on the date stated above, at 4:30 a. m.

The CAUSE OF DEATH* was as follows:

Status Epilepticus

(Duration) yrs. mos. 3 ds.

Contributory Secondary

Epileptic Insanity

(Duration) yrs. mos. ds.

(Signed)

J. Percy Wade, M. D.

(Address)

Catonville Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death 1 yrs. 11 mos. 20 ds. In the State yrs. mos. ds.

Where was disease contracted, If not at place of death?

Former or usual residence Baltimore, Md.

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Green Mount Cem. May 23, 1914

20 UNDERTAKER

ADDRESS

H. H. Meers & Son 805 N. Calvert St.

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

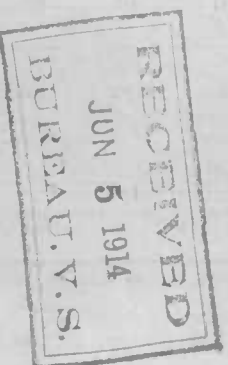
[Approved by U. S. Census and American Public Health Association.]

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Statement of cause of death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritonaeum*, etc., *Carcin-*

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1 PLACE OF DEATH 4633

County BaltimoreVillage or City St. Agnes Hospital (No.)Registration Dist. No. 42St. Ward

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME Mary Hopkins

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) Single

6 DATE OF BIRTH October 18, 1904
(Month) (Day) (Year)

7 AGE 9 yrs. 7 mos. 5 ds. If LESS than 1 day, hrs. OR min. ?

8 OCCUPATION
(a) Trade, profession, or particular kind of work Schoolgirl
(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE (State or country) Baltimore Md.

10 NAME OF FATHER Charles Hopkins

11 BIRTHPLACE OF FATHER (State or country) Maryland

12 MAIDEN NAME OF MOTHER Sallie Dover

13 BIRTHPLACE OF MOTHER (State or country) Maryland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Irma Hopkins(Address) 1929 Hollins St.

15 Filed May 23, 1914 Geo. A. Stewart
REGISTRAR

STATE OF MARYLAND
CERTIFICATE OF DEATH

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH May 23, 1914
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from , 191 , to , 191 .

that I last saw h. alive on May 23, 1914.

and that death occurred on the date stated above, at 3:45 P. M.

The CAUSE OF DEATH* was as follows:

Accidental Struck with automobile

(Duration) yrs. mos. ds.
Contributory Fracture ribs right & left side
Secondary Shock & hemorrhage

(Signed) Geo. A. Stewart, M. D.

May 23, 1914 (Address) St. Agnes Hospital

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence 1929 Hollins St.

19 PLACE OF BURIAL OR REMOVAL Lawson Park DATE OF BURIAL May 26, 1914

20 UNDERTAKER J. J. Carvan ADDRESS 901 Hollins

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

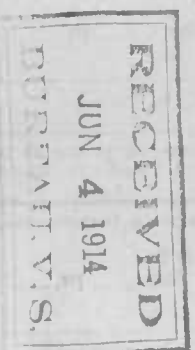
[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcin-*

oma, Sarcoma, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Tranema," "Weakness" etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state MEANS OF INJURY and qualify as ACCIDENTAL, suicidal, or homicidal, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carboic acid—probably suicide*. The nature of the injury, as fracture of skull and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.



WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH 4634		<div style="border: 1px solid black; border-radius: 50%; width: 60px; height: 60px; display: flex; align-items: center; justify-content: center; font-size: 40px; margin: 0 auto;">91</div> STATE OF MARYLAND CERTIFICATE OF DEATH Registration Dist. No. 444	
County <u>Baltimore</u>			
Village or City <u>Spinnertown</u> (No. <u>23</u> , <u>Chesapeake</u> Ward)		[If death occurred in a hospital or institution, give its NAME instead of street and number.]	
2 FULL NAME <u>Joseph Henry Hertz</u>			
PERSONAL AND STATISTICAL PARTICULARS			
3 SEX <u>M</u>	4 COLOR OR RACE <u>W.</u>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) <u>Single</u>	
6 DATE OF BIRTH <u>February 9</u> (Month) (Day) (Year) <u>1914</u>			
7 AGE <u>4</u> yrs. <u>2</u> mos. <u>2</u> ds.		If LESS than 1 day, hrs. OR min. ?	
8 OCCUPATION (a) Trade, profession, or particular kind of work <u>Wm.</u> (b) General nature of industry, business, or establishment in which employed (or employer)			
9 BIRTHPLACE (State or country) <u>Spinnertown, Md.</u>			
PARENTS	10 NAME OF FATHER <u>John Hertz</u>		
	11 BIRTHPLACE OF FATHER (State or country) <u>Prussia</u>		
	12 MAIDEN NAME OF MOTHER <u>Theresa Jacobluch</u>		
13 BIRTHPLACE OF MOTHER (State or country) <u>Prussia</u>			
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>John Hertz</u> (Address) <u>Spinnertown</u>			
15 FILED <u>May 18</u> , 1914 <u>Ed McCormick M.D.</u> REGISTRAR			
MEDICAL CERTIFICATE OF DEATH			
16 DATE OF DEATH <u>May 16</u> , 1914 (Month) (Day) (Year)			
17 I HEREBY CERTIFY, That I attended deceased from <u>May 8</u> , 1914, to <u>May 14</u> , 1914, that I last saw him alive on <u>May 12</u> , 1914, and that death occurred on the date stated above, at <u>8 a</u> m.			
The CAUSE OF DEATH* was as follows: <u>Brunstles Pneumonia</u>			
(Duration) yrs. mos. <u>18</u> ds.			
Contributory Secondary			
(Duration) yrs. mos. ds.			
(Signed) <u>F. G. Eldred</u> , M. D., <u>May 16</u> , 1914. (Address) <u>Spinnertown</u>			
*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.			
18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS) At place of death yrs. mos. ds. In the State yrs. mos. ds. Where was disease contracted, If not at place of death? Former or usual residence			
19 PLACE OF BURIAL OR REMOVAL <u>St. Stanislaus</u>		DATE OF BURIAL <u>May 18</u> , 1914	
20 UNDERTAKER <u>William Gialkowski</u>		ADDRESS <u>1618 Eastern Ave.</u>	

If more blanks are needed, address State Registrar, 1111 ... V. S. No. 1.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

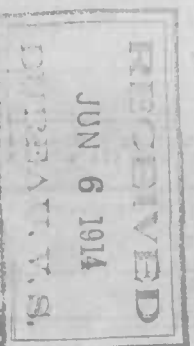
[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer." "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Former (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcin-*

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1 PLACE OF DEATH

County BaltimoreSTATE OF MARYLAND
CERTIFICATE OF DEATHRegistered No. 27Village or City Texas (No. _____ St. _____ Ward _____)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME Mary Jane Hundermark

PERSONAL AND STATISTICAL PARTICULARS

3 SEX female 4 COLOR OR RACE white 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) Divorced6 DATE OF BIRTH Dec 12, 1894
(Month) (Day) (Year)7 AGE 94 yrs. 5 mos. 10 ds. If LESS than 1 day, ____ hrs. OR ____ min. ?

8 OCCUPATION

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

Housewife

9 BIRTHPLACE (State or country)

Balto Co.

10 NAME OF FATHER

Isaac Weissener

11 BIRTHPLACE OF FATHER (State or country)

U.S.

12 MAIDEN NAME OF MOTHER

Mary Bosley

13 BIRTHPLACE OF MOTHER (State or country)

U.S.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Alma Home Record(Address) Texas Md15 Filed May 23, 1914 P.B. Benson REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH May 22, 1914
(Month) (Day) (Year)17 I HEREBY CERTIFY That I attended deceased from Jan 1, 1914 to May 22, 1914, that I last saw him alive on May 19, 1914and that death occurred on the date stated above, at 10 a. m.

The CAUSE OF DEATH* was as follows:

Senility + Arterio Sclerosisacute (Duration) 5 yrs. ____ mos. ____ ds.

Contributory (Secondary)

(Duration) ____ yrs. ____ mos. ____ ds.

(Signed) P.B. Benson M. D.May 22, 1914 (Address) Chickensville Md

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death 6 yrs. 1 mos. ____ ds. In the State ____ yrs. ____ mos. ____ ds.

Where was disease contracted,

If not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

Pleasant Grove

DATE OF BURIAL

May 23, 1914

20 UNDERTAKER

U. C. Brinks

ADDRESS

Sparks Md

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

V. S. No. 1.

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REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

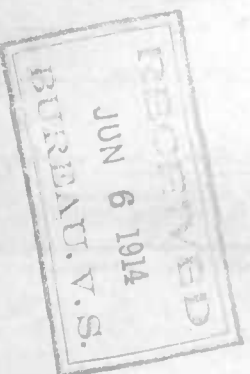
[Approved by U. S. Census and American Public Health Association.]

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Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Group"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcin-*

oma, *Sarcoma*, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*, *Chronic valvular heart disease*, *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 *ds.*; *Bronchopneumonia* (secondary), 10 *ds.* Never report mere symptoms or terminal conditions, such as "Anæmia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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1 PLACE OF DEATH 4636

County Baltimore

90 STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No. 41Village or City Highlandtown (No. 3219 Fleet St St.; Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME Thomas R. Hurd.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Widower
(Write the word)

6 DATE OF BIRTH June 1, 1875
(Month) (Day) (Year)

7 AGE 38 yrs. 11 mos. 4 ds. If LESS than 1 day, hrs. OR min. ?

8 OCCUPATION (a) Trade, profession, or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE (State or country) Pennsylvania

PARENTS 10 NAME OF FATHER Patrick Hurd.
11 BIRTHPLACE OF FATHER (State or country) Ireland
12 MAIDEN NAME OF MOTHER Bridget Hookahan
13 BIRTHPLACE OF MOTHER (State or country) Ireland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Bridget Hurd
(Address) 3219 Fleet St

15 Filed May 7, 1914 W. E. McClaughan
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH May 5th, 1914
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from April 25, 1914 to May 5, 1914, that I last saw him alive on May 5, 1914

and that death occurred on the date stated above, at 7:30 P. m.
The CAUSE OF DEATH* was as follows:

Bronchiectasis

(Duration) 2 yrs. 2 mos. 0 ds.

Contributory Dilated heart
Secondary

(Duration) 12 yrs. 0 mos. 0 ds.

(Signed) W. J. McAvoy, M. D.
May 7, 1914 (Address) 839 S. Elmwood

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death 0 yrs. 0 mos. 0 ds. In the State 0 yrs. 0 mos. 0 ds.

Where was disease contracted, If not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL Sacred Heart Cem. DATE OF BURIAL May 8th, 1914

20 UNDERTAKER Lilly & Co. Gruber. ADDRESS 403 S. Wolfe

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

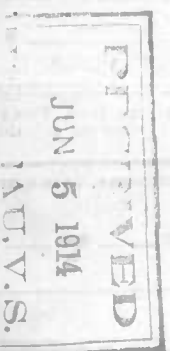
REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

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1 PLACE OF DEATH

County Balto 4637STATE OF MARYLAND
CERTIFICATE OF DEATHRegistered No. 33Village or City St George (No. MD) St.; Ward

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME Sarah E. Hutchison

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE white 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED widow
(Write the word)6 DATE OF BIRTH April 8, 1869
(Month) (Day) (Year)7 AGE 55 yrs. 1 mos. 21 ds. If LESS than 1 day, hrs. OR min. ?8 OCCUPATION
(a) Trade, profession, or particular kind of work House keeper
(b) General nature of industry, business, or establishment in which employed (or employer)9 BIRTHPLACE (State or country) Adams Co Pa10 NAME OF FATHER Adam Leese11 BIRTHPLACE OF FATHER (State or country) Adams Co Pa12 MAIDEN NAME OF MOTHER Mary A. Masemore13 BIRTHPLACE OF MOTHER (State or country) Adams Co Pa

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mary J. Leese
(Address) Glen Morris MD15 Filed May 30, 1914 St George

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH May 29, 1914
(Month) (Day) (Year)17 I HEREBY CERTIFY, That I attended deceased from under 1914, to May 29, 1914.
that I last saw her alive on May 28, 1914and that death occurred on the date stated above, at 6 a m,
The CAUSE OF DEATH* was as follows:Carcinoma of breast(Duration) 4 yrs. mos. ds.
Contributory Secondary cancer
(Secondary)(Signed) J. H. Ekins, M. D.
May 30, 1914 (Address) St George

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL Restatoun County DATE OF BURIAL May 31, 191420 UNDERTAKER J. F. Ekins ADDRESS Restatoun

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

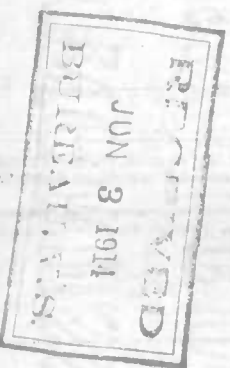
[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not rainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritonaeum*, etc. *Carcin-*

oma, *Sarcoma*, etc., of _____ (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congential," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and quality as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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1 PLACE OF DEATH

4638

County

Baltimore

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registered No.

28

Village or City

Melrose

(No.

St.

Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME

Rosie Jackson

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

Negro

5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word)

Single

6 DATE OF BIRTH

1897

(Month)

(Day)

(Year)

7 AGE

17

yrs.

mos.

ds.

If LESS than 1 day, hrs. OR min. ?

8 OCCUPATION

(a) Trade, profession, or particular kind of work.

Nothing

(b) General nature of industry, business, or establishment in which employed (or employer)

Mentally Weak

9 BIRTHPLACE (State or country)

Maryland

10 NAME OF FATHER

Unknown

11 BIRTHPLACE OF FATHER (State or country)

Unknown

12 MAIDEN NAME OF MOTHER

Unknown

13 BIRTHPLACE OF MOTHER (State or country)

Unknown

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Florence S. Cunningham, Sup

(Address)

Industrial Home Co. 412 Melrose

15

Filed

June 2, 1914 M. J. Porter

REGISTRAR

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

May 31

(Month)

(Day)

1914 (Year)

17

I HEREBY CERTIFY, That I attended deceased from

March 15

1914, to

May 31

1914

that I last saw him alive on

May 29

1914

and that death occurred on the date stated above, at 7 P. M.

The CAUSE OF DEATH* was as follows:

Chronic Tuberculosis

Contributory (Secondary)

(Duration)

yrs.

mos.

ds.

(Signed)

W. W. Wimer

M. D.

June 1, 1914

(Address)

1220 2 1/2 St. ...

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place

of death

yrs.

mos.

ds.

In the

State

yrs.

mos.

ds.

Where was disease contracted, If not at place of death?

Former or

usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Melrose Home

June 2, 1914

20 UNDERTAKER

ADDRESS

H. S. Marshall 3539 Fall Road

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Furn laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not faintly employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc.. *Carcin-*

oma, *Sarcoma*, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.*; *Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "As-thenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state MEANS OF INJURY and quality as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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JUL 6 1914

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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1 PLACE OF DEATH County <u>Balto</u>		4639		STATE OF MARYLAND CERTIFICATE OF DEATH	
Village or City <u>Colgate Creek</u> (No. <u>German Hill Rd.</u> St.; Ward)		Registration Dist. No. <u>41</u>		[If death occurred in a hospital or institution, give its NAME instead of street and number.]	
2 FULL NAME <u>Elizabeth Johnson</u>					
PERSONAL AND STATISTICAL PARTICULARS					
3 SEX <u>Female</u>	4 COLOR OR RACE <u>Negro</u>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED <u>married</u> (Write the word)			
6 DATE OF BIRTH <u>March 22, 1887</u> (Month) (Day) (Year)					
7 AGE <u>57</u> yrs. <u>2</u> mos. <u>6</u> ds.		8 IF LESS than 1 day, hrs. OR min. ?			
9 OCCUPATION (a) Trade, profession, or particular kind of work <u>House work</u> (b) General nature of industry, business, or establishment in which employed (or employer) <u>at home</u>					
10 BIRTHPLACE (State or country) <u>MD</u>					
PARENTS	10 NAME OF FATHER <u>Theodore Staten</u>				
	11 BIRTHPLACE OF FATHER (State or country) <u>MD</u>				
	12 MAIDEN NAME OF MOTHER <u>not known</u>				
	13 BIRTHPLACE OF MOTHER (State or country) <u>not known</u>				
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>John H. Johnson</u> (Address) <u>Colgate Creek, Balto.</u>					
15 Filed <u>May 29, 1914</u> <u>W. E. McClanahan</u> REGISTRAR					
MEDICAL CERTIFICATE OF DEATH					
16 DATE OF DEATH <u>May 28, 1914</u> (Month) (Day) (Year)					
17 I HEREBY CERTIFY, That I attended deceased from <u>May 27, 1914</u> to <u>May 28, 1914</u> . that I last saw her alive on <u>May 28, 1914</u> and that death occurred on the date stated above, at <u>10 A. M.</u> The CAUSE OF DEATH* was as follows: <u>Exhaustion + Typhoid</u>					
Contributory <u>Exhaustion + Typhoid</u> Secondary <u>Exhaustion + Typhoid</u> (Duration) yrs. mos. ds. <u>8</u> ds. (Signed) <u>A. M. Wright</u> , M. D. <u>May 28, 1914</u> (Address) <u>St. Andrew's</u>					
*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.					
18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS) At place of death yrs. mos. ds. <u>1</u> yrs. <u>2</u> mos. <u>6</u> ds. State <u>MD</u> Where was disease contracted, If not at place of death? Former or usual residence.					
19 PLACE OF BURIAL OR REMOVAL <u>Willow Grove Cemetery</u>				DATE OF BURIAL <u>May 30, 1914</u>	
20 UNDERTAKER <u>H. Sander & Sons</u>				ADDRESS <u>1710 8th St</u>	

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

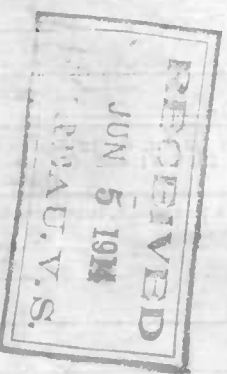
[Approved by U. S. Census and American Public Health Association.]

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Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcin-*

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1 PLACE OF DEATH 4640

County BaltimoreVillage or City Friskysville (No. Franklin Ave St. Ward)Registration Dist. No. 43

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME Mary Agnes Johnson

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Single
(Write the word)

6 DATE OF BIRTH June 6, 1905
(Month) (Day) (Year)

7 AGE 8 yrs. 11 mos. 12 ds. OR 1 day, 12 hrs. 12 min. ?
If LESS than 1 day, hrs. min. ?

8 OCCUPATION
(a) Trade, profession, or particular kind of work at School
(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE (State or country) Balto Co

10 NAME OF FATHER Charles F. Johnson

11 BIRTHPLACE OF FATHER (State or country) Baltimore

12 MAIDEN NAME OF MOTHER Mary A. Scott

13 BIRTHPLACE OF MOTHER (State or country) Balto

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Chas F. Johnson(Address) Franklin Ave & Belair Rd

15 Filed May 19, 1914 W. H. Claytor
REGISTRAR

STATE OF MARYLAND
CERTIFICATE OF DEATH

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH May 19, 1914
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from May 19, 1914
191, to May 19, 1914

that I last saw her alive on July 18, 1914

and that death occurred on the date stated above, at 1 a. m.

The CAUSE OF DEATH* was as follows: Scarlet Fever

Contributory (Duration) 1 yrs. 1 mos. 1 ds.
Secondary meningitis

(Signed) W. H. Claytor, M. D.
May 19, 1914 (Address) Overbrook

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death 1 yrs. 1 mos. 1 ds. In the State 1 yrs. 1 mos. 1 ds.

Where was disease contracted, If not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL Mr. Elbert DATE OF BURIAL May 19, 1914

20 UNDERTAKER W. H. Claytor & Co ADDRESS 2008 Orleans

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

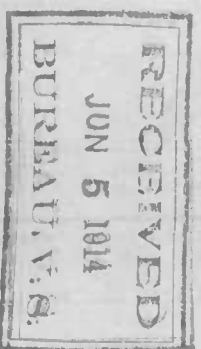
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Statement of cause of death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc.. *Carcin-*

oma, *Sarcoma*, etc., of _____ (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 20 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Anemia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For violent DEATHS state MEANS OF INJURY and quality as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such. If impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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RECEIVED

JUN 5 1914

BUREAU, V. S.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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1 PLACE OF DEATH County <u>Baltimore</u>		4642	(91)	STATE OF MARYLAND CERTIFICATE OF DEATH	
Village or City <u>Spencerville</u> (No. <u>409</u>)		St. _____ Ward _____		Registration Dist. No. <u>44</u>	
2 FULL NAME <u>Alice L. Jones</u>					
PERSONAL AND STATISTICAL PARTICULARS					
3 SEX <u>Female</u>	4 COLOR OR RACE <u>Black</u>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) <u>Single</u>			
6 DATE OF BIRTH <u>Nov. 25 1912</u> (Month) <u>11</u> (Day) <u>25</u> (Year) <u>1912</u>		16 DATE OF DEATH <u>May 18</u> , 19 <u>14</u> (Month) (Day) (Year)			
7 AGE <u>1</u> yrs. <u>5</u> mos. <u>23</u> ds.		17 I HEREBY CERTIFY that I attended deceased from <u>May 12</u> , 19 <u>14</u> , to <u>May 18</u> , 19 <u>14</u> , that I last saw her alive on <u>May 18</u> , 19 <u>14</u> , and that death occurred on the date stated above, at <u>1 P.</u> m.			
8 OCCUPATION (a) Trade, profession, or particular kind of work. <u>None</u> (b) General nature of industry, business, or establishment in which employed (or employer)		The CAUSE OF DEATH* was as follows: <u>Brunella Pneumonia</u>			
9 BIRTHPLACE (State or country) <u>Spencerville</u>		Contributory <u>Examination</u> Secondary			
10 NAME OF FATHER <u>Andrew J. Jones</u>		(Duration) _____ yrs. _____ mos. _____ ds.			
11 BIRTHPLACE OF FATHER (State or country) <u>DC</u>		(Signed) <u>Frank C. Eddies</u> , M. D. <u>May 18</u> , 19 <u>14</u> (Address) <u>Spencerville</u>			
12 MAIDEN NAME OF MOTHER <u>Murtha Oliver</u>		*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.			
13 BIRTHPLACE OF MOTHER (State or country) <u>DC</u>		18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS) At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds. Where was disease contracted, If not at place of death? _____ Former or usual residence _____			
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>Andrew J. Jones</u> (Address) <u>609 2nd Spencerville</u>					
15 Filed <u>May 18, 1914</u> <u>H. McCormick</u> REGISTRAR		19 PLACE OF BURIAL OR REMOVAL <u>Spencerville Cem.</u>		DATE OF BURIAL <u>May 20</u> , 19 <u>14</u>	
		20 UNDERTAKER <u>Armstrong Denny Co.</u>		ADDRESS <u>Balto.</u>	

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

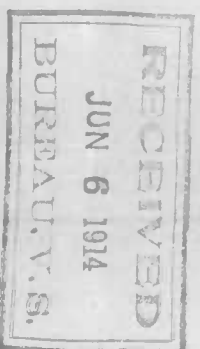
[Approved by U. S. Census and American Public Health Association.]

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Statement of cause of death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcin-*

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1 PLACE OF DEATH

4643

STATE OF MARYLAND
CERTIFICATE OF DEATH

County

Balt

Registration Dist. No.

269

Village or City

Highland

(No. 105

S. Bouldin St.;

Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME

Andrew Jones

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 SINGLE,
MARRIED,
WIDOWED,
OR DIVORCED
(Write the word)

Married

6 DATE OF BIRTH

Feb. 21st

(Month)

(Day)

1879
(Year)

7 AGE

35

yrs.

2

mos.

27

ds.

If LESS than
1 day, ____ hrs.
OR ____ min. ?

8 OCCUPATION

(a) Trade, profession, or
particular kind of work.

Foreman

(b) General nature of industry,
business, or establishment in
which employed (or employer)

Cannemaker

9 BIRTHPLACE

(State or country)

Maryland

10 NAME OF
FATHER

Samuel Jones

11 BIRTHPLACE
OF FATHER
(State or country)

Penn.

12 MAIDEN NAME
OF MOTHER

Barbarba Robb

13 BIRTHPLACE
OF MOTHER
(State or country)

Germany

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Rose Jones

(Address)

105 S. Bouldin St.

15

Filed

May 20, 1914

W. E. McClanahan

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

May

18th

1914

(Month)

(Day)

(Year)

17

I HEREBY CERTIFY, That I attended deceased from

April 19, 1914, to

May 17th, 1914.

that I last saw him alive on

May 17th, 1914.

and that death occurred on the date stated above, at

5:45 a.m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(Duration)

7 yrs.

mos.

ds.

Contributory
Secondary

(Duration)

yrs.

mos.

ds.

(Signed)

Adam A. Tod

M. D.

(Address)

May 19, 1914 (Address) 3019 Eastern Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place

of death

yrs. mos. ds.

to the

State

yrs. mos. ds.

Where was disease contracted,

If not at place of death?

Former or

usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Oak Lawn Cem.

May 21st, 1914

20 UNDERTAKER

ADDRESS

W. H. Sander Sons

1710 Fleet St.

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

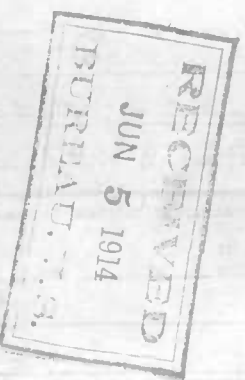
REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

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1 PLACE OF DEATH			STATE OF MARYLAND CERTIFICATE OF DEATH	
County <u>Balto</u>			Registration Dist. No. <u>4</u>	
Village or City <u>Bolgate</u> (No. <u>5th Ave</u>)			St.; _____ Ward _____	
2 FULL NAME <u>John Jones</u>				
PERSONAL AND STATISTICAL PARTICULARS				
3 SEX <u>Male</u>	4 COLOR OR RACE <u>White</u>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED <u>Married</u> (Write the word)		
6 DATE OF BIRTH <u>Apr. 1870</u> (Month) (Day) (Year)				
7 AGE <u>44</u> yrs. — mos. — ds. If LESS than 1 day, — hrs. OR — min. ?				
8 OCCUPATION (a) Trade, profession, or particular kind of work <u>White Washer</u> (b) General nature of industry, business, or establishment in which employed (or employer)				
9 BIRTHPLACE (State or country) <u>Llel</u>				
PARENTS				
10 NAME OF FATHER <u>Unknown</u>				
11 BIRTHPLACE OF FATHER (State or country) <u>"</u>				
12 MAIDEN NAME OF MOTHER <u>"</u>				
13 BIRTHPLACE OF MOTHER (State or country) <u>"</u>				
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE Informant <u>Mary Jones</u> (Address) <u>5th Ave</u>				
15 Filed <u>May 19 - 1914</u> <u>W. E. McClanahan</u> REGISTRAR				
MEDICAL CERTIFICATE OF DEATH				
16 DATE OF DEATH <u>May 17</u> , 191 <u>4</u> (Month) (Day) (Year)				
17 I HEREBY CERTIFY, That I attended deceased from <u>May 16</u> , 191 <u>4</u> , to <u>May 17</u> , 191 <u>4</u> , that I last saw him alive on <u>May 17</u> , 191 <u>4</u> , and that death occurred on the date stated above, at <u>1:15 P</u> m. The CAUSE OF DEATH* was as follows: <u>Acute alcoholism</u> <u>ursemic convulsion</u> (Duration) <u>X</u> yrs. <u>X</u> mos. <u>1</u> ds. Contributory (Secondary) <u>alcoholism</u> (Duration) <u>X</u> yrs. <u>X</u> mos. <u>2</u> ds. (Signed) <u>Jar. L. Miller</u> , M. D. <u>May 17</u> , 191 <u>4</u> (Address) <u>248 So Third</u> *State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.				
18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS) At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds. Where was disease contracted, If not at place of death? _____ Former or usual residence _____				
19 PLACE OF BURIAL OR REMOVAL <u>Asbury Cem</u>			DATE OF BURIAL <u>May 18, 1914</u>	
20 UNDERTAKER <u>Philp Henry Orleans</u>			ADDRESS <u>2016</u>	

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

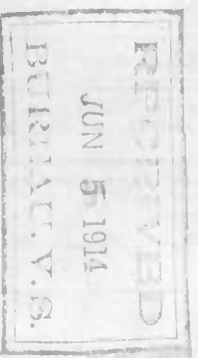
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1 PLACE OF DEATH

4645

County

Baltimore

Village or City

Reisterstown

(No.

Md

Registration Dist. No.

33

St.; Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME

Mary A Joyce

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White

5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word)

Married

6 DATE OF BIRTH

May 7, 1834

7 AGE

80 yrs. — mos. — ds.

If LESS than 1 day, hrs. OR min. ?

8 OCCUPATION

(a) Trade, profession, or particular kind of work

None

(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE

(State or country)

Baltimore Co Md

10 NAME OF FATHER

Charles A. Peacock

11 BIRTHPLACE OF FATHER

(State or country)

Unknown

12 MAIDEN NAME OF MOTHER

Esther Alder

13 BIRTHPLACE OF MOTHER

(State or country)

Baltimore Co Md

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Geo Hazel

(Address)

Reisterstown Md

15

Filed

May 6, 1914

REGISTRAR

STATE OF MARYLAND
CERTIFICATE OF DEATH

MEDICAL CERTIFICATE OF DEATH

18 DATE OF DEATH

May 6, 1914

17 I HEREBY CERTIFY, That I attended deceased from

Apr. 25th, 1914, to May 6th, 1914.that I last saw her alive on May 6th, 1914.

and that death occurred on the date stated above, at 8:30 P. M.

The CAUSE OF DEATH* was as follows:

Fracture of Femur
Due to fall
XRB (Duration) yrs. — mos. 11 ds.

Contributory

Secondary

(Duration) yrs. — mos. — ds.

(Signed) J. H. Blair M. D.

May 7, 1914 (Address) Reisterstown

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. — mos. — ds. In the State yrs. — mos. — ds.

Where was disease contracted, If not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Stone Chapel Cemetery May 8, 1914

20 UNDERTAKER

ADDRESS

J. H. Blair Reisterstown Md

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

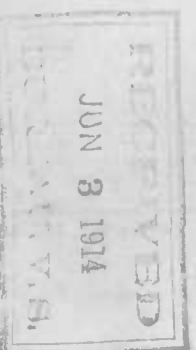
[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mining*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcin-*

oma, Sarcoma, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Con-fertal" "Senile" etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæ-mia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For vio-lent deaths state means of injury and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—acci-dent*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomencla-ture of the American Medical Association.)

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WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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PLACE OF DEATH			STATE OF MARYLAND	
County <u>Baltimore</u>			CERTIFICATE OF DEATH	
Village or City <u>Raspburg</u> (No. <u>4646</u>)			Registered No. <u>43</u>	
FULL NAME <u>William Keating</u>			[If death occurred in a hospital or institution, give its NAME instead of street and number.]	
PERSONAL AND STATISTICAL PARTICULARS				
1 SEX <u>M.</u>	4 COLOR OR RACE <u>White</u>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) <u>Widower</u>		
6 DATE OF BIRTH <u>12</u> <u>6</u> <u>1839</u> (Month) (Day) (Year)				
7 AGE <u>74</u> yrs. <u>5</u> mos. <u>20</u> ds. If LESS than 1 day, hrs. OR min. ?				
8 OCCUPATION (a) Trade, profession, or particular kind of work <u>Farmer's Manager</u> (b) General nature of industry, business, or establishment in which employed (or employer) <u>Directing work on farms.</u> (Retired)				
9 BIRTHPLACE (State or country) <u>Md.</u>				
10 NAME OF FATHER <u>(Name Unknown) Keating</u>				
11 BIRTHPLACE OF FATHER (State or country) <u>Ireland</u>				
12 MAIDEN NAME OF MOTHER <u>Unknown</u>				
13 BIRTHPLACE OF MOTHER (State or country) <u>Unknown</u>				
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>Mrs. John H. Enders</u> (Address) <u>Raspburg, Md.</u>				
15 Filed <u>May 28, 1914</u> <u>W. H. Clayton</u> REGISTRAR				
MEDICAL CERTIFICATE OF DEATH				
16 DATE OF DEATH <u>5</u> <u>26</u> <u>1914</u> (Month) (Day) (Year)				
17 I HEREBY CERTIFY, That I attended deceased from <u>May 25</u> , 1914, to <u>May 26</u> , 1914, that I last saw him alive on <u>May 25</u> , 1914, and that death occurred on the date stated above, at <u>8:15 P. m.</u> , The CAUSE OF DEATH* was as follows: <u>Acute Cardiac Dilatation</u> <u>Four hours.</u> (Duration) yrs. mos. ds.				
Contributory (Secondary) (Probably) <u>Pulmonary Tuberculosis</u> (Duration) ? yrs. mos. ds.				
(Signed) <u>D. L. McElwain</u> , M. D. <u>5-26-</u> , 1914. (Address) <u>Raspburg</u>				
*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.				
18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS) At place of death yrs. mos. ds. in the State yrs. mos. ds. Where was disease contracted, if not at place of death? Former or usual residence.				
19 PLACE OF BURIAL OR REMOVAL <u>Chester town Cemetery</u>			DATE OF BURIAL <u>May 30</u> , 1914	
20 UNDERTAKER <u>Frank Lassarum Sons</u>			ADDRESS <u>Fulton Ind.</u>	

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

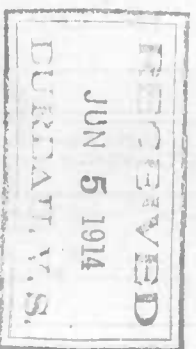
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Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc. *Carcin-*

oma, *Sarcoma*, etc., of _____ (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Anæmia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congential," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and quality as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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1915
749
Dec 6-18 39
S-M



WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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1 PLACE OF DEATH			STATE OF MARYLAND	
County <u>Baltimore</u>			CERTIFICATE OF DEATH	
Village or City <u>Glencoe</u>			Registered No. <u>38</u>	(If death occurred in a hospital or institution, give its NAME instead of street and number.)
2 FULL NAME <u>John Henry Keene</u>				
PERSONAL AND STATISTICAL PARTICULARS				
3 SEX <u>male</u>	4 COLOR OR RACE <u>white</u>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED <u>married</u> (Write the word)		
6 DATE OF BIRTH <u>May 1836</u> (Month) (Day) (Year)				
7 AGE <u>78</u> yrs. — mos. — ds.		If LESS than 1 day, hrs. OR mo. ?		
8 OCCUPATION (a) Trade, profession, or particular kind of work <u>Atty. at Law</u> (b) General nature of industry, business, or establishment in which employed (or employer)				
9 BIRTHPLACE (State or country) <u>Unknown</u>				
PARENTS	10 NAME OF FATHER <u>John Henry Keene</u>			
	11 BIRTHPLACE OF FATHER (State or country) <u>Unknown</u>			
	12 MAIDEN NAME OF MOTHER <u>Sarah L. Dorsey</u>			
	13 BIRTHPLACE OF MOTHER (State or country) <u>Unknown</u>			
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>Richman Craig</u> (Address) <u>Govanus Rd.</u>				
15 Filed <u>May 7, 1914</u> M. G. P. O. L. <u>Deputy Local REGISTRAR</u>				
MEDICAL CERTIFICATE OF DEATH				
16 DATE OF DEATH <u>May 8, 1914</u> (Month) (Day) (Year)				
17 I HEREBY CERTIFY That I attended deceased from <u>Mar 26, 1913</u> , to <u>May 6, 1914</u> , that I last saw him alive on <u>May 6, 1914</u> , and that death occurred on the date stated above, at <u>6:30 P.M.</u> , The CAUSE OF DEATH* was as follows: <u>Refractory Chronic Intermittent</u>				
(Duration) <u>2</u> yrs. — mos. — ds.				
Contributory (Secondary) <u>Marasmus Curia</u>				
(Signed) <u>Geo. L. F. Mohr</u> , M. D. <u>May 7, 1914</u> (Address) <u>1130 N. 20. Fayette St.</u>				
*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.				
18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS) At place of death _____ yrs. — mos. — ds. In the State _____ yrs. — mos. — ds. Where was disease contracted, If not at place of death? Former or usual residence _____				
19 PLACE OF BURIAL OR REMOVAL <u>Green Mount</u> DATE OF BURIAL <u>May 8, 1914</u>				
20 UNDERTAKER <u>E. W. Mitchell</u> ADDRESS <u>201 N. Fayette</u>				

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

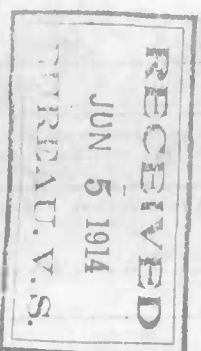
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oma, *Sarcoma*, etc., of _____ (name organ; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 *ds.*; *Bronchopneumonia* (secondary), 10 *ds.* Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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1 PLACE OF DEATH 4648
 County *Baltimore*

Village or City *Orangerville* (No. *11th* St.; Ward)

2 FULL NAME *None*

151 STATE OF MARYLAND
 CERTIFICATE OF DEATH

Registered No. *43*

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Female* 4 COLOR OR RACE *White* 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) *Single*

6 DATE OF BIRTH *May 5, 1914*
 (Month) (Day) (Year)

7 AGE *11* LESS than 1 day, 6 hrs. OR min. ?
 yrs. mos. ds.

8 OCCUPATION
 (a) Trade, profession, or particular kind of work *None*
 (b) General nature of industry, business, or establishment in which employed (or employer) *None*

9 BIRTHPLACE (State or country) *Baltimore*

10 NAME OF FATHER *Allen F. Keller*

11 BIRTHPLACE OF FATHER (State or country) *Baltimore*

12 MAIDEN NAME OF MOTHER *William Moore*

13 BIRTHPLACE OF MOTHER (State or country) *Baltimore*

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) *Allen F. Keller*

(Address) *Orangerville Md*

15 Filed *May 4, 1914* *W. E. McClanahan*

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH *May 5, 1914*
 (Month) (Day) (Year)

I HEREBY CERTIFY, That I attended deceased from *May 5, 1914* to *May 5, 1914*

that I last saw her alive on *May 5, 1914*

and that death occurred on the date stated above, at *12 P. m.*

THE CAUSE OF DEATH* was as follows:

Obituary

(Duration) yrs. mos. ds.

Contributory (Secondary) *Inevitable abortion*

(Duration) yrs. mos. ds.

(Signed) *Dr. J. J. Sullivan*, M. D.
May 6, 1914 (Address) *330 E. Pratt St*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, If not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL *Johns Hopkins* DATE OF BURIAL *May 5, 1914*

20 UNDERTAKER *W. E. P. Miller* ADDRESS *Johns Hopkins*

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting 7. B. No. 1.

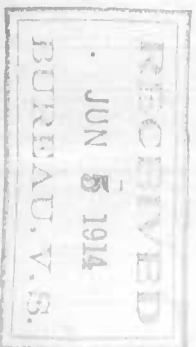
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[Approved by U. S. Census and American Public Health Association.]

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1 PLACE OF DEATH

4649

91

STATE OF MARYLAND
CERTIFICATE OF DEATHCounty BaltoRegistered No. 30Village or City Franklinston (No. Franklin Road St.; Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME

Frank Kleeman Jr

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE white 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) Single6 DATE OF BIRTH Dec 4, 1913
(Month) (Day) (Year)7 AGE 6 yrs. 6 mos. ds. If LESS than 1 day, hrs. OR min. ?8 OCCUPATION
(a) Trade, profession, or particular kind of work. None
(b) General nature of industry, business, or establishment in which employed (or employer)9 BIRTHPLACE (State or country) Balti Co Md10 NAME OF FATHER Frank Kleeman11 BIRTHPLACE OF FATHER (State or country) Balti Co Md12 MAIDEN NAME OF MOTHER Florence Smith13 BIRTHPLACE OF MOTHER (State or country) Md

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Frank Kleeman(Address) Franklinston Md15 Filed May 28, 1914 Marshall B. Woot

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH May 28, 1914
(Month) (Day) (Year)17 I HEREBY CERTIFY, That I attended deceased from May 28, 1914 to May 28, 1914that I last saw him alive on May 28, 1914and that death occurred on the date stated above, at 7:30 am

The CAUSE OF DEATH* was as follows:

Bronch pneumonia
not known

(Duration) yrs. mos. ds.

Contributory (Secondary)

Bronch pneumonia

(Duration) yrs. mos. ds.

(Signed) W. S. Niblett, M. D.191 (Address) Kernan Hospital

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, If not at place of death?

Former or usual residence.

19 PLACE OF BURIAL OR REMOVAL Salem Lutheran Ch DATE OF BURIAL May 28, 191420 UNDERTAKER John C. Hough Co ADDRESS 1422 Penna av

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

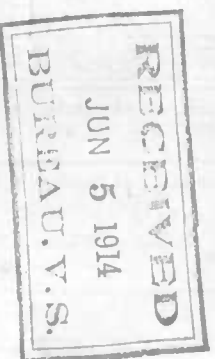
[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not faithfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the **DISEASE CAUSING DEATH** (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritonaeum*, etc. *Carcin-*

oma, *Sarcoma*, etc., of (name origin; "Gancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congential," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Infantion," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and quality as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.



WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH

4650

County

Balto

 STATE OF MARYLAND
 CERTIFICATE OF DEATH

Registration Dist. No.

 [If death occurred in
 a hospital or institution,
 give its NAME instead
 of street and number.]

Village or City

Colgate

(No.)

St.

Ward)

2 FULL NAME

Matthew Krug

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 SINGLE,
MARRIED,
WIDOWED,
OR DIVORCED
(Write the word)

Widower

6 DATE OF BIRTH

Unknown

(Month)

(Day)

(Year)

7 AGE

55

yrs.

mos.

ds.

If LESS than
1 day, hrs.
OR min. ?

8 OCCUPATION

(a) Trade, profession, or
particular kind of work

Laborer m

(b) General nature of industry,
business, or establishment in
which employed (or employer)

Fishing shore.

9 BIRTHPLACE

(State or country)

Cld.

PARENTS

10 NAME OF
FATHER

Unknown

11 BIRTHPLACE
OF FATHER
(State or country)

Unknown

12 MAIDEN NAME
OF MOTHER

Unknown

13 BIRTHPLACE
OF MOTHER
(State or country)

Unknown

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

William Krug

(Address)

Sollers Pt. Cld.

15

Filed

May 30, 1914

W. E. W. Clarkson M.D.

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

5 29, 1914

(Month)

(Day)

(Year)

17

I HEREBY CERTIFY, That I attended deceased from

191, to

191

that I last saw h. alive on 191

and that death occurred on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Probable Pneumonia

(Duration) yrs. mos. ds.

Contributory
Secondary

(Duration) yrs. mos. ds.

(Signed)

A. Warner, M. D.

May 29, 1914 (Address) Sollers Pt.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT
CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL,
SUICIDAL, or HOMICIDAL.16 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS,
OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted,
If not at place of death?Former or
usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Schwartz Cemetery June 1, 1914

20 UNDERTAKER

Lilly & Zeiler

ADDRESS

403 S. Wolfe St.

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

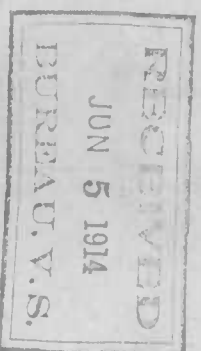
[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*; (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcin-*

oma, Sarcoma, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Træmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDE, or HOMICIDE, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—Homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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1 PLACE OF DEATH 4651

County BaltVillage or City Rashburg (No. _____, St.; _____ Ward)

(S) STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No. 43

[If death occurred in
a hospital or institution,
give its NAME instead
of street and number.]

2 FULL NAME Still Born of Gertie & Clara Kupusch

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Single
(Write the word)

6 DATE OF BIRTH May 3, 1914
(Month) (Day) (Year)

7 AGE _____ yrs. _____ mos. _____ ds. If LESS than 1 day, _____ hrs. OR _____ min. ?

8 OCCUPATION
(a) Trade, profession, or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer) _____

9 BIRTHPLACE (State or country) Ind

PARENTS
10 NAME OF FATHER Gertie Kupusch
11 BIRTHPLACE OF FATHER (State or country) Germany
12 MAIDEN NAME OF MOTHER Clara Koch
13 BIRTHPLACE OF MOTHER (State or country) Ind

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Gertie Kupusch(Address) Rashburg

15 Filed May 5, 1914 W. H. Clayton
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH May 3, 1914
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from _____, 191____, to _____, 191____.

that I last saw h. _____, alive on _____, 191____.

and that death occurred on the date stated above, at _____ m.

The CAUSE OF DEATH* was as follows:
Still Born

Contributory
Secondary

(Duration) _____ yrs. _____ mos. _____ ds.
(Signed) W. H. Clayton, M. D.
May 5, 1914 (Address) Overbury

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds.

Where was disease contracted, If not at place of death? _____

Former or usual residence _____

19 PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

St. Joseph's Cemetery May 5, 1914
20 UNDERTAKER ADDRESS
Gertie Kupusch Rashburg

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

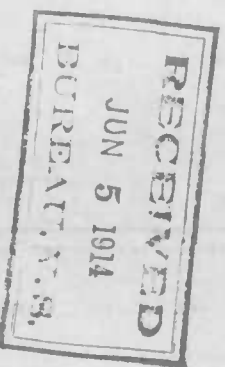
[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Plumber*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcin-*

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PLACE OF DEATH

4652

County BaltimoreVillage or City Brownson (No. _____, St.; _____ Ward)STATE OF MARYLAND
CERTIFICATE OF DEATHRegistered No. 34

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

FULL NAME Emma Katherine Larrison

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE white 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED single
(Write the word)

6 DATE OF BIRTH May - 21st, 1904
(Month) (Day) (Year)

7 AGE _____ yrs. _____ mos. _____ ds. If LESS than 1 day, 2 hrs. OR 15 min. ?

OCCUPATION

(a) Trade, profession, or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer) _____

BIRTHPLACE
(State or country)Brownson

PARENTS

10 NAME OF FATHER

Clyde Larrison11 BIRTHPLACE OF FATHER
(State or country)Anne Arundel Co. Md.

12 MAIDEN NAME OF MOTHER

Emma Katherine Buckingham13 BIRTHPLACE OF MOTHER
(State or country)Carroll Co.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Clyde Larrison

(Address)

Brownson, Md.

15

Filed May 22, 1914 Henry A. Taylor

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH May 21, 1914
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from

_____, 191____, to _____, 191____,
that I last saw h. _____ alive on _____, 191____

and that death occurred on the date stated above, at _____ m.
The CAUSE OF DEATH* was as follows:

demonstrative disease ?
new born — one hour & 15 min.
(Duration) yrs. mos. ds.
Contributory unknown
(Secondary)

(Signed) Severin C. Smith
(Duration) yrs. mos. ds.
(Address) Pikesville

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds.

Where was disease contracted,
if not at place of death?

Former or
usual residence _____

19 PLACE OF BURIAL OR REMOVAL

Stone Chapel

DATE OF BURIAL

May 22, 1914

20 UNDERTAKER

C. H. Kraft

ADDRESS

Pikesville

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

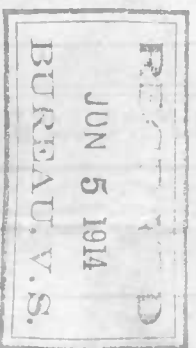
[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Composer*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mining*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc. *Carcin-*

oma, *Sarcoma*, etc., of _____ (name origin: "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 *ds.*; *Bronchopneumonia* (secondary), 10 *ds.* Never report mere symptoms or terminal conditions, such as "Anthemia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congestial," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "Puerperal septichemia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state MEANS OF INJURY and quality as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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1 PLACE OF DEATH 4653

County BaltoVillage or City Highland (No. 7, 11 St.; Ward)2 FULL NAME Lena Janetta LawSTATE OF MARYLAND
CERTIFICATE OF DEATHRegistration Dist. No. 41

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) single

6 DATE OF BIRTH May 18, 1914
(Month) (Day) (Year)

7 AGE 2 yrs. 2 mos. 2 ds. If LESS than 1 day, hrs. OR min. ?

8 OCCUPATION
(a) Trade, profession, or particular kind of work —
(b) General nature of industry, business, or establishment in which employed (or employer) —

9 BIRTHPLACE (State or country) MD

PARENTS
10 NAME OF FATHER Henry Vincent
11 BIRTHPLACE OF FATHER (State or country) unknown
12 MAIDEN NAME OF MOTHER Myrtle Law
13 BIRTHPLACE OF MOTHER (State or country) MD

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Myrtle Law(Address) 9-11 St

15 Filed May 21, 1914 W. E. McCauley
REGISTRAR MD

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH May 20, 1914
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from 1914, to 1914,

that I last saw him alive on 1914

and that death occurred on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Ganosis

(Duration) — yrs. — mos. — ds.

Contributory —
Secondary —

(Signed) W. E. McCauley, M. D.
May 20, 1914 (Address) Coroner

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death — yrs. — mos. — ds. In the State — yrs. — mos. — ds.

Where was disease contracted, If not at place of death?

Former or usual residence —

19 PLACE OF BURIAL OR REMOVAL Schwartz's Cem. DATE OF BURIAL May 21, 1914

20 UNDERTAKER Lilly & Zailer ADDRESS 403 S. Wolfst.

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

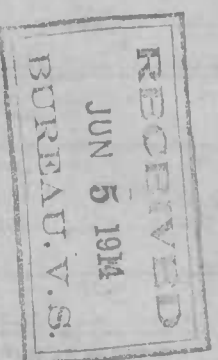
[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Composer*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not faithfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritonaeum*, etc., *Carcin-*

oma, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Træmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.



WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH

4654

County

Balto

Village or City

Hamilton (No. Park av.

Registration Dist. No.

58

St.; Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME

Elizabeth A. Legg

PERSONAL AND STATISTICAL PARTICULARS

3 SEX female 4 COLOR OR RACE white 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) Widower

6 DATE OF BIRTH May 21, 1914 (Month) (Day) (Year)

7 AGE 72 yrs. 7 mos. 15 ds. If LESS than 1 day, hrs. OR min. ?

8 OCCUPATION (a) Trade, profession, or particular kind of work housework (b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE (State or country) Baltimore

10 NAME OF FATHER John Keefer

11 BIRTHPLACE OF FATHER (State or country) Kentucky

12 MAIDEN NAME OF MOTHER Not Known

13 BIRTHPLACE OF MOTHER Balto Md

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Alexander Haysman

(Address)

Hamilton Md.

15

Filed

May 5, 1914

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH May 4, 1914 (Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from Dec 15, 1913, to May 4, 1914.

that I last saw her alive on May 4, 1914.

and that death occurred on the date stated above, at 3:45 p. m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(Duration) yrs. mos. ds.

Contributory (Secondary) Myocarditis & Arteriosclerosis

(Duration) yrs. mos. ds.

(Signed) Claude Smith, M. D.

May 4, 1914. (Address) Fairville Md

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, If not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Woodlawn Cemetery May 6, 1914

20 UNDERTAKER ADDRESS

Low Cost 5026 York

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative wealthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Group"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritonaeum*, etc. *Carcin-*

oma, *Sarcoma*, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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RECEIVED

JUN 5 1914

BUREAU, V. S.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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1 PLACE OF DEATH 4655

County BaltimoreVillage or City Parkville (No. _____)STATE OF MARYLAND
CERTIFICATE OF DEATHRegistered No. 38

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME William Leonhardt

PERSONAL AND STATISTICAL PARTICULARS

3 SEX male 4 COLOR OR RACE white 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED married
(Write the word)

6 DATE OF BIRTH April 29, 1843
(Month) (Day) (Year)

7 AGE 71 yrs. 10 mos. 10 ds. If LESS than 1 day, ____ hrs. OR ____ min. ?

8 OCCUPATION (a) Trade, profession, or particular kind of work Wagon Manufacturer
(b) General nature of industry, business, or establishment in which employed (or employer) Employer

9 BIRTHPLACE (State or country) Baltimore md

10 NAME OF FATHER Henry Leonhardt

11 BIRTHPLACE OF FATHER (State or country) Germany

12 MAIDEN NAME OF MOTHER Katherine Meyers

13 BIRTHPLACE OF MOTHER (State or country) Germany

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Edward M. Leonhardt
(Address) 3004 Ellerslie ave

15 Filed 5/9, 1914 Clara Swier
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH May 8, 1914
(Month) (Day) (Year)

17 I HEREBY CERTIFY That I attended deceased from April 30, 1914 to May 8, 1914

that I last saw him alive on May 8, 1914

and that death occurred on the date stated above, at 7:40 pm

The CAUSE OF DEATH* was as follows:

Acute Gastro-Enteritis

(Duration) ____ yrs. ____ mos. 9 ds.

Contributory (Secondary) Acute Nephritis

(Duration) ____ yrs. ____ mos. 9 ds.

(Signed) Monis B. Green M. D.

May 9, 1914 (Address) Hamilton Rd

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR REGENT RESIDENTS)

At place of death ____ yrs. ____ mos. ____ ds. In the State ____ yrs. ____ mos. ____ ds.

Where was disease contracted, If not at place of death?

Former or usual residence _____

19 PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Druid Ridge 5-12, 1914

20 UNDERTAKER ADDRESS

J. B. Efeuse 1325 N. Caroline

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

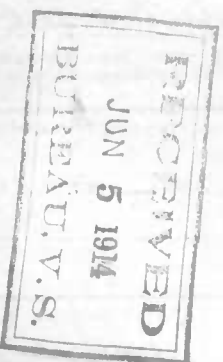
[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc. *Carcin-*

oma, *Sarcoma*, etc., of _____ (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronicular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 *ds.*; *Bronchopneumonia* (secondary), 10 *ds.* Never report mere symptoms or terminal conditions, such as "Anemia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congital" "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state MEANS OF INJURY and quality as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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1 PLACE OF DEATH County <u>Baltimore</u>		4656		STATE OF MARYLAND CERTIFICATE OF DEATH	
Village or City <u>Pikesville</u> (No. <u>79</u>)		St; Ward		Registered No. <u>32</u>	
2 FULL NAME <u>Samuel P. Lewin</u>					
PERSONAL AND STATISTICAL PARTICULARS					
3 SEX <u>Male</u>	4 COLOR OR RACE <u>White</u>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED <u>Married</u> (Write the word)			
6 DATE OF BIRTH <u>8</u> <u>19</u> <u>1882</u> (Month) (Day) (Year)					
7 AGE <u>52</u> yrs. — mos. — ds. If LESS than 1 day, hrs. OR min. ?					
8 OCCUPATION (a) Trade, profession, or particular kind of work. <u>Black Smith</u> (b) General nature of industry, business, or establishment in which employed (or employer) _____					
9 BIRTHPLACE (State or country) <u>Maryland</u>					
PARENTS	10 NAME OF FATHER <u>Saml. Lewin</u>				
	11 BIRTHPLACE OF FATHER (State or country) <u>England</u>				
	12 MAIDEN NAME OF MOTHER <u>Elizabeth Fee</u>				
13 BIRTHPLACE OF MOTHER (State or country) <u>Maryland</u>					
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>Hetara Lewin</u> (Address) <u>Pikesville</u>					
15 Filed <u>May 31, 1914</u> <u>Henry A. Taylor</u> REGISTRAR					
MEDICAL CERTIFICATE OF DEATH					
16 DATE OF DEATH <u>5</u> <u>31</u> <u>1914</u> (Month) (Day) (Year)					
17 I HEREBY CERTIFY, That I attended deceased from <u>for several</u> yrs. 191 <u>4</u> to 191 <u>4</u> , that I last saw him alive on <u>May 31</u> , 191 <u>4</u> , and that death occurred on the date stated above, at <u>8:15 A. M.</u> , The CAUSE OF DEATH* was as follows: <u>Valvular disease of heart</u> <u>unknown</u> (Duration) yrs. mos. ds. Contributory (Secondary) <u>Rheumatism</u> <u>unknown</u> (Duration) yrs. mos. ds. (Signed) <u>W. O. Thompson</u> , M. D. <u>5</u> <u>31</u> , 191 <u>4</u> (Address) <u>Pikesville Md</u>					
*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.					
18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS) At place of death yrs. mos. ds. In the State yrs. mos. ds. Where was disease contracted, If not at place of death? Former or usual residence _____					
19 PLACE OF BURIAL OR REMOVAL <u>Dauk Ridge</u>				DATE OF BURIAL <u>June 13</u> , 191 <u>4</u>	
20 UNDERTAKER <u>C. H. Knight</u>				ADDRESS <u>Pikesville</u>	

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

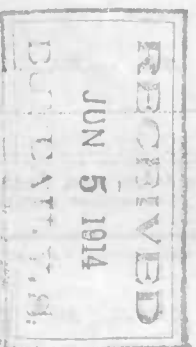
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(a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mining*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc. *Carcin-*

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1 PLACE OF DEATH 4657
County Balto.

Village or City Crofton (No. _____ St.; _____ Ward)

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registered No. 38

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME William Locks

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE Col 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Married
(Write the word)

6 DATE OF BIRTH June —, 1875
Month (Day) (Year)

7 AGE 38 yrs. 11 mos. — ds. If LESS than 1 day, hrs. OR min. ?

8 OCCUPATION
(a) Trade, profession, or particular kind of work Cook
(b) General nature of industry, business, or establishment in which employed (or employer) Cook

9 BIRTHPLACE (State or country) Md.

10 NAME OF FATHER James Locks

11 BIRTHPLACE OF FATHER (State or country) Md.

12 MAIDEN NAME OF MOTHER Bettie Chew

13 BIRTHPLACE OF MOTHER (State or country) Md.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Louise Locks
(Address) Crofton

15 Filed 5/24, 1914 Claud Smith
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH May 23, 1914
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That attended deceased from May 16, 1914, to May 23, 1914,

that I last saw him alive on May 23, 1914,

and that death occurred on the date stated above, at 10 P. m.

The CAUSE OF DEATH* was as follows:

Solar Pneumonia

(Duration) — yrs. — mos. 9 ds.

Contributory (Secondary) Myocarditis

(Duration) — yrs. — mos. 4 ds.

(Signed) J. R. Green, M. D.

May 23, 1914 (Address) Crofton Md.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds.

Where was disease contracted, If not at place of death?

Former or usual residence _____

19 PLACE OF BURIAL OR REMOVAL Western Cemetery DATE OF BURIAL May 26, 1914
Calvert Co

20 UNDERTAKER John Burns Sons ADDRESS Towson

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc.. *Carcin-*

oma, *Sarcoma*, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 *ds.*; *Bronchopneumonia* (secondary), 10 *ds.* Never report mere symptoms or terminal conditions, such as "Anthrax," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congential," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state MEANS OF INJURY and qualify as ACCIDENTAL, suicidal, or homicidal, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

RECEIVED
JUN 5 1914
BUREAU U. V. S.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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1 PLACE OF DEATH

4658

County

Baltimore

Village or City

Ruston

(No.

Registration Dist. No.

38

St.; Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME

Bridget Gordon

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

white

5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word)

widow

6 DATE OF BIRTH

not known

(Month) (Day) (Year)

7 AGE

about 81 yrs. — mos. — ds.

If LESS than 1 day, hrs. OR min. ?

8 OCCUPATION

(a) Trade, profession, or particular kind of work

at home

(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE (State or country)

Ireland

10 NAME OF FATHER

Patrick Scott

PARENTS

11 BIRTHPLACE OF FATHER (State or country)

Ireland

12 MAIDEN NAME OF MOTHER

Ellen (not known)

13 BIRTHPLACE OF MOTHER (State or country)

Ireland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Daniel A. Gordon

(Address)

608 E. Priddy St. Baltimore

15

Filed

5/3-1914

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

May 3, 1914
(Month) (Day) (Year)

17

I HEREBY CERTIFY, That I attended deceased from

about 1896 to May 3, 1914

that I last saw him alive on May 3, 1914

and that death occurred on the date stated above, at 5:45 p.m.

The CAUSE OF DEATH* was as follows:

Carcinoma of the intestine
celio caeco region

about (Duration) 2 yrs. — mos. — ds.

Contributory (Secondary)

(Signed) Williams J. Todd, M. D.

May 4, 1914 (Address) Mt Washington Md.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

St. Mary's Gorman

DATE OF BURIAL

May 6, 1914

20 UNDERTAKER

H. C. Bridgfield

ADDRESS

914 Greenmount Ave.

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer*—(coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Group"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc.. *Carcin-*

oma, *Sarcoma*, etc., of _____ (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.*; *Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Anaemia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congential," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "Puerperal septichæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be sketched under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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RECEIVED

JUN 5 1914

BUREAU, V. S.

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1 PLACE OF DEATH

4659

42

STATE OF MARYLAND
CERTIFICATE OF DEATHCounty *Baltimore*Registered No. *35*Village or City *Cheswold* (No. *Taney Road* St; Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME *Marcella M. Lyons*

PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Female*4 COLOR OR RACE *White*5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) *Single*

6 DATE OF BIRTH

October, 1864
(Month) (Day) (Year)

7 AGE

57 yrs. — mos. — ds. OR min. ?
If LESS than 1 day, — hrs.

8 OCCUPATION

(a) Trade, profession, or particular kind of work *None*

(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE (State or country)

Carroll Co Md

10 NAME OF FATHER

Richard Lyons

11 BIRTHPLACE OF FATHER (State or country)

Ireland

12 MAIDEN NAME OF MOTHER

Luzenza Baker

13 BIRTHPLACE OF MOTHER (State or country)

Carroll Co Md

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

J. W. Lyons

(Address)

Taney Road

15

Filed *May 17*, 1914 *Henry O. Taylor*
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

5 - 14, 1914
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from

10 - 1, 1913, to *5 - 14*, 1914.that I last saw him alive on *5 - 14*, 1914.and that death occurred on the date stated above, at *6 P.* m.

The CAUSE OF DEATH* was as follows:

Carcinoma of uterus and appendages
by carcinoma of uterus(Duration) *uncertain* yrs. — mos. — ds.

Contributory (Secondary)

Exhaustion

(Duration) — yrs. — mos. — ds.

(Signed) *A. S. Barnett*, M. D.*5-15*, 1914 (Address) *1631 Madison*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR REGENT RESIDENTS)

At place of death — yrs. — mos. — ds. In the State — yrs. — mos. — ds.

Where was disease contracted, If not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Druid Ridge *May 18*, 1914

20 UNDERTAKER

ADDRESS

Mr. M. Gaultney *901 W. Main*
ave

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

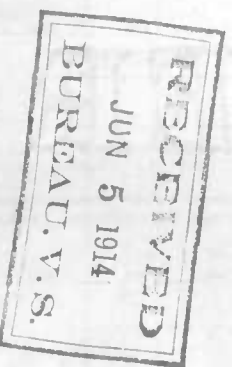
[Approved by U. S. Census and American Public Health Association.]

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1 PLACE OF DEATH <i>Balto.</i>		4660		(138)		STATE OF MARYLAND CERTIFICATE OF DEATH	
County		Village or City		Registration Dist. No.		[If death occurred in a hospital or institution, give its NAME instead of street and number.]	
		<i>Sparrow Point 231 East E</i>		<i>44</i>			
2 FULL NAME		<i>Margaret M. McCall</i>					
PERSONAL AND STATISTICAL PARTICULARS							
3 SEX <i>Female</i>	4 COLOR OR RACE <i>white</i>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED <i>married.</i> (Write the word)					
6 DATE OF BIRTH <i>March 17th 1874</i>							
(Month) (Day) (Year)							
7 AGE <i>40</i> yrs. <i>1</i> mos. <i>25</i> ds.		8 LESS than 1 day.....hrs. OR.....min. ?					
9 OCCUPATION (a) Trade, profession, or particular kind of work (b) General nature of industry, business, or establishment in which employed (or employer)		<i>Housewife</i> <i>Housewife</i>					
10 BIRTHPLACE (State or country)		<i>Ireland</i>					
PARENTS	10 NAME OF FATHER <i>Michael O'Donnell</i>						
	11 BIRTHPLACE OF FATHER (State or country)		<i>Ireland</i>				
	12 MAIDEN NAME OF MOTHER <i>Margaret Flaherty</i>						
13 BIRTHPLACE OF MOTHER (State or country)		<i>Ireland</i>					
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <i>Deem's McCall</i> (Address) <i>Sparrow Point</i>							
15 Filed <i>May 13th 1914</i>		16 REGISTRAR <i>J. J. McCormick</i>					
MEDICAL CERTIFICATE OF DEATH							
16 DATE OF DEATH <i>May 12th 1914</i>		(Month) (Day) (Year)					
17 I HEREBY CERTIFY, That I attended deceased from <i>May 6th 1912</i> to <i>May 12th 1914</i> that I last saw her alive on <i>May 12th 1914</i> and that death occurred on the date stated above, at <i>8 a.</i> m. The CAUSE OF DEATH* was as follows: <i>Uremic poisoning</i> (Duration) yrs. mos. ds. Contributory <i>Advanced pregnancy</i> Secondary (Duration) yrs. mos. ds. (Signed) <i>G. J. McCormick</i> , M. D. <i>May 13, 1914</i> (Address) <i>Sparrow Point</i> *State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.							
18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS) At place of death yrs. mos. ds. In the State yrs. mos. ds. Where was disease contracted, If not at place of death? Former or usual residence.....							
19 PLACE OF BURIAL OR REMOVAL <i>Holy Cross Cemetery</i>				DATE OF BURIAL <i>May 15, 1914</i>			
20 UNDERTAKER <i>John A. Moraw</i>				ADDRESS <i>Balto.</i>			

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

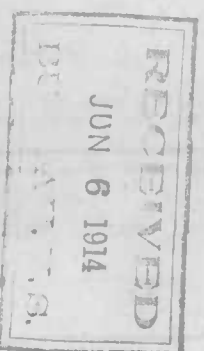
[Approved by U. S. Census and American Public Health Association.]

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Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritonaeum*, etc., *Carcin-*

oma, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL *septicæmia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For violent DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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1 PLACE OF DEATH 4661
 County Baltimore
 Village or City Sparrows Point (No. 231 East C) St.; Ward 44
2 FULL NAME (still born) infant McCall

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male **4 COLOR OR RACE** white **5 SINGLE, MARRIED, WIDOWED, OR DIVORCED** Single
 (Write the word)
6 DATE OF BIRTH May 12th, 1914
 (Month) (Day) (Year)
7 AGE — yrs. — mos. — ds. **OR LESS than** 1 day, — hrs. — mos. ?

8 OCCUPATION
 (a) Trade, profession, or particular kind of work none
 (b) General nature of industry, business, or establishment in which employed (or employer) none

9 BIRTHPLACE (State or country) Sparrows Point Md

PARENTS
10 NAME OF FATHER Dennis McCall
11 BIRTHPLACE OF FATHER (State or country) Penna
12 MAIDEN NAME OF MOTHER Margaret O'Donnell
13 BIRTHPLACE OF MOTHER (State or country) Ireland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Dennis McCall
 (Address) Sparrows Point

15 Filed May 13th, 1914 G. J. McCormick
 REGISTRAR

STATE OF MARYLAND
CERTIFICATE OF DEATHRegistration Dist. No. 44

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH May 12th, 1914
 (Month) (Day) (Year)

17 I HEREBY CERTIFY That I attended deceased from 191 to 191

that I last saw him alive on 191

and that death occurred on the date stated above, at m

The CAUSE OF DEATH* was as follows:

Still born

(Duration) — yrs. — mos. — ds.

Contributory uremic poisoning of
 Secondary mother

(Signed) G. J. McCormick, M. D.

May 13, 1914 (Address) Sparrows Point

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death — yrs. — mos. — ds. In the State — yrs. — mos. — ds.

Where was disease contracted, If not at place of death? —

Former or usual residence —

19 PLACE OF BURIAL OR REMOVAL Holy Cross Cem. **DATE OF BURIAL** May 15, 1914

20 UNDERTAKER John A. Moran **ADDRESS** Balto.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

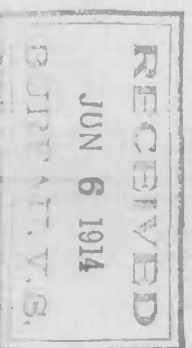
[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*; *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Furn laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcin-*

oma, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal *septicæmia*," "Puerperal *peritonitis*," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Reverber wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.



WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PLACE OF DEATH			STATE OF MARYLAND	
County			CERTIFICATE OF DEATH	
Baltimore			Registered No. 43	
Village or City Raspeburg (No. 11 Rockdale Ave St.)			Ward)	
[If death occurred in a hospital or institution, give its NAME instead of street and number.]				
FULL NAME Edward J. McCleary				
PERSONAL AND STATISTICAL PARTICULARS				
SEX M	COLOR OR RACE W	MARRIED, WIDOWED, OR DIVORCED (Write the word) married		
DATE OF BIRTH June 25, 1864 (Month) (Day) (Year)				
AGE 49 yrs. 11 mos. 15 ds. If LESS than 1 day, hrs. OR min. ?				
OCCUPATION (a) Trade, profession, or particular kind of work Printer (b) General nature of industry, business, or establishment in which employed (or employer) Composing Room				
BIRTHPLACE (State or country) Md				
PARENTS				
10 NAME OF FATHER Edward McCleary				
11 BIRTHPLACE OF FATHER (State or country) Md				
12 MAIDEN NAME OF MOTHER Mary - (unknown)				
13 BIRTHPLACE OF MOTHER (State or country) Md				
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) Charlotte McCleary (Address) Raspeburg Md				
15 Filed May 12, 1914 W. H. Clayton REGISTRAR				
MEDICAL CERTIFICATE OF DEATH				
16 DATE OF DEATH May 10, 1914 (Month) (Day) (Year)				
17 I HEREBY CERTIFY, That I attended deceased from Jan. 1914 to May 10, 1914, that I last saw him alive on May 10, 1914, and that death occurred on the date stated above, at 2 P. m. The CAUSE OF DEATH* was as follows: Cerebral Hemorrhage				
Contributory (Secondary) Hypertension + Ch. Replasia (Duration) yrs. mos. 8 ds.				
(Signed) A. J. Wilkinson, M. D. 5-12, 1914 (Address) Raspeburg (Duration) ? yrs. mos. ds.				
*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.				
18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS) At place of death yrs. mos. ds. In the State yrs. mos. ds. Where was disease contracted, If not at place of death? Former or usual residence.				
19 PLACE OF BURIAL OR REMOVAL DATE OF BURIAL Baltimore Cem. May 13, 1914				
20 UNDERTAKER ADDRESS Wendell Lippel & Son 37 S. Anne St.				

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

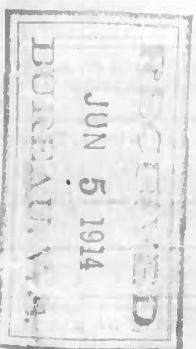
[Approved by U. S. Census and American Public Health Association.]

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Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Group"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc.. *Carcin-*

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1 PLACE OF DEATH

4663

115

STATE OF MARYLAND
CERTIFICATE OF DEATHCounty BaltimoreRegistrars' Dist. No. 42Village or City St. Agnes Hospital (No. _____)

St. _____ Ward _____

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME

Miss Ellen Mc Dermott

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White5 SINGLE,
MARRIED,
WIDOWED,
OR DIVORCED
(Write the word)Single

6 DATE OF BIRTH

Dec. 30, 1837
(Month) (Day) (Year)

7 AGE

76 yrs. 4 mos. 21 ds.
OR 1 day, _____ hrs. _____ min. ?
It LESS than 1 day, _____ hrs.

8 OCCUPATION

(a) Trade, profession, or particular kind of work

None

(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE

(State or country)

New York

PARENTS

10 NAME OF FATHER

David Mc Dermott

11 BIRTHPLACE OF FATHER

(State or country)

Ireland

12 MAIDEN NAME OF MOTHER

Ellen Collins

13 BIRTHPLACE OF MOTHER

(State or country)

Ireland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs. Florence Hobbs(Address) 237 Mc Carley Street

15

Filed May 21, 1914 Georgetown

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

May 21, 1914
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from

May 9, 1914, to May 21, 1914.that I last saw her alive on May 21, 1914and that death occurred on the date stated above, at 7:15 p.m.

The CAUSE OF DEATH* was as follows:

Ruptured
Acute peritonitis

(Duration) _____ yrs. _____ mos. _____ ds.

Contributory

Secondary

Ruptured empyema of gall-bladder
& gallstones.

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed)

Jas. C. Stowers

, M. D.

5/21, 1914 (Address) St. Agnes Hosp.

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18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds.

Where was disease contracted, It not at place of death?

Former or usual residence 237 Mc Carley Street

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Bonne Brac Cem.May 25, 1914

20 UNDERTAKER

ADDRESS

W. M. Gawthrop901 W. North Ave.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

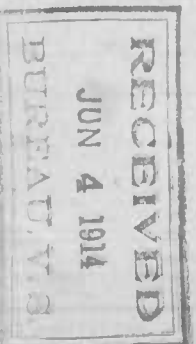
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1 PLACE OF DEATH County <u>Baltimore</u>		4664		STATE OF MARYLAND CERTIFICATE OF DEATH	
Village or City <u>Sparrow Point</u> (No. <u>902</u>)		St. _____ Ward _____		Registration Dist. No. <u>44</u>	
2 FULL NAME <u>Still born infant Madison</u>					
PERSONAL AND STATISTICAL PARTICULARS					
3 SEX <u>Male</u>	4 COLOR OR RACE <u>col</u>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) <u>single</u>			
6 DATE OF BIRTH <u>May 25th</u> , 19 <u>14</u> (Month) (Day) (Year)					
7 AGE _____ yrs. _____ mos. _____ ds. IF LESS than 1 day _____ hrs. OR min. ?					
8 OCCUPATION (a) Trade, profession, or particular kind of work <u>none</u> (b) General nature of industry, business, or establishment in which employed (or employer) <u>none</u>					
9 BIRTHPLACE (State or country) <u>Sparrow Point Md</u>					
PARENTS	10 NAME OF FATHER <u>James Madison</u>				
	11 BIRTHPLACE OF FATHER (State or country) <u>Virginia</u>				
	12 MAIDEN NAME OF MOTHER <u>Josephine Dupree</u>				
	13 BIRTHPLACE OF MOTHER (State or country) <u>Virginia</u>				
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>James Madison</u> (Address) <u>902 J. St.</u>					
15 FILED <u>May 26</u> , 19 <u>14</u> <u>G. P. McCoon</u> REGISTRAR					
MEDICAL CERTIFICATE OF DEATH					
16 DATE OF DEATH <u>May 25th</u> , 19 <u>14</u> (Month) (Day) (Year)					
17 I HEREBY CERTIFY, That I attended deceased from _____, 19____, to _____, 19____, that I last saw him _____ alive on _____, 19____, and that death occurred on the date stated above, at _____ m, The CAUSE OF DEATH* was as follows: <u>Still born</u>					
Contributory (Duration) _____ yrs. _____ mos. _____ ds. Secondary <u>prolapse of Junie</u> (Signed) <u>G. P. McCoon</u> , M. D. <u>May 25</u> , 19 <u>14</u> (Address) <u>Sparrow Point</u>					
*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.					
18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS) At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds. Where was disease contracted, If not at place of death? _____ Former or usual residence _____					
19 PLACE OF BURIAL OR REMOVAL <u>Sparrow Point Cemetery</u>				DATE OF BURIAL <u>May 26</u> , 19 <u>14</u>	
20 UNDERTAKER <u>Armstrong Denny & Co</u>				ADDRESS <u>Balto.</u>	

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

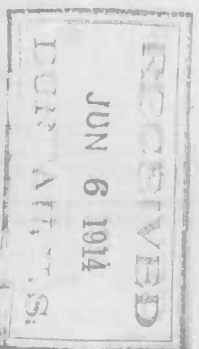
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1 PLACE OF DEATH

4665

County

*Baltimore*STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No.

41

Village or City

Highlandtown (No. *3572*)*Hudson St*

Ward

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME

Paul Mai

PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Male* 4 COLOR OR RACE *White* 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED *Single*
(Write the word)

6 DATE OF BIRTH

March 25, 1887
(Month) (Day) (Year)

7 AGE

27 yrs. *1* mos. *25* ds.If LESS than
1 day, hrs.
OR min. ?

8 OCCUPATION

(a) Trade, profession, or particular kind of work

Baker

(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE

(State or country)

Baltimore City

PARENTS

10 NAME OF FATHER

Henry Mai

11 BIRTHPLACE OF FATHER

(State or country)

Germany

12 MAIDEN NAME OF MOTHER

Rosa Huber

13 BIRTHPLACE OF MOTHER

(State or country)

Germany

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Henry Mai

(Address)

3572 Hudson St

15

Filed

May 22, 1914 *W.E. McLaughlin*

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

May 20, 1914
(Month) (Day) (Year)

17

I HEREBY CERTIFY, That I attended deceased from

*Nov 1/13, 1911 to May 20/14, 1914*that I last saw him alive on *Sept 12, 1911*and that death occurred on the date stated above, at *4 A.* m.

The CAUSE OF DEATH* was as follows:

Phthisis Pulmonalis(Duration) *6* mos. *6* ds.Contributory
Secondary*G.I. B. Sanguis -**Malnutrition* (Duration) *1* mos. *1* ds.(Signed) *+ R. Herrmann*, M. D.*5/20/14* (Address) *2919 B. Balt St*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death *0* yrs. *0* mos. *0* ds. In the State *0* yrs. *0* mos. *0* ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

*Schwartz Am.**May 23, 1914*

20 UNDERTAKER

ADDRESS

*Lilly and Ziehl**403 S. W. 1st*

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Cooling*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcin-*

oma, Sarcoma, etc., *of*..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and qualify as ACCIDENTAL, suicidal, or homicidal, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—Homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

RECEIVED
JUN 5 1914
BUREAU U. S.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH 4666

County

Baltimore

Village or City

Chase

(No. _____)

St.; _____ Ward)

Registration Dist. No. 44

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME

Edgar Landover Martin

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

Caucasian

5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word)

Single

6 DATE OF BIRTH

Jan 29, 1914
(Month) (Day) (Year)

7 AGE

3 yrs. 2 mos. 2 ds. If LESS than 1 day, _____ hrs. OR _____ min. ?

8 OCCUPATION

(a) Trade, profession, or particular kind of work

Student

(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE (State or country)

Maryland

PARENTS

10 NAME OF FATHER

Hos Martin

11 BIRTHPLACE OF FATHER (State or country)

Maryland

12 MAIDEN NAME OF MOTHER

Virginia Williams

13 BIRTHPLACE OF MOTHER (State or country)

Maryland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Moses Martin

(Address)

Chase Md

15

Filed

May 3, 1914

REGISTRAR

STATE OF MARYLAND
CERTIFICATE OF DEATH

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

May 2, 1914
(Month) (Day) (Year)

17

I HEREBY CERTIFY, That I attended deceased from

_____, 191____, to _____, 191____.

that I last saw him _____ alive on _____, 191____.

and that death occurred on the date stated above, at 9 a. m.

The CAUSE OF DEATH* was as follows:

Capillary Bronchitis

(Duration) _____ yrs. _____ mos. 14 ds.

Contributory (Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed)

Charles Root

M. D.

May 2, 1914 (Address) Edgewood Md

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

16 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds.

Where was disease contracted, if not at place of death? _____

Former or usual residence _____

19 PLACE OF BURIAL OR REMOVAL

Sharp St Cem

DATE OF BURIAL

May 3, 1914

20 UNDERTAKER

Chas Fenty

ADDRESS

Rossow

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

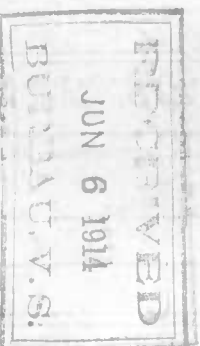
[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry; and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not handsomely employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc. *Carcin-*

oma, *Sarcoma*, etc., of _____ (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 10 ds. Never report *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congential," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state MEANS OF DEATH and quality as ACCIDENTAL, suicidal, or homicidal, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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1 PLACE OF DEATH Baltimore 4667
 County Baltimore
 Village or City Rockland (No. Falls Road St. Ward)
 2 FULL NAME William Albert Martin
 Registration Dist. No. 32
 [If death occurred in a hospital or institution, give its NAME instead of street and number.]

PERSONAL AND STATISTICAL PARTICULARS

3 SEX <u>Male</u>	4 COLOR OR RACE <u>White</u>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) <u>Married</u>
6 DATE OF BIRTH <u>September 5, 1871</u> (Month) (Day) (Year)		
7 AGE <u>42</u> yrs. <u>8</u> mos. <u>4</u> ds.		If LESS than 1 day, hrs. OR min. ?
8 OCCUPATION (a) Trade, profession, or particular kind of work <u>Manager Groceries & Meat</u> (b) General nature of industry, business, or establishment in which employed (or employer) <u>dry goods, manufacturing</u>		
9 BIRTHPLACE (State or country) <u>Balto Co Md</u>		
PARENTS	10 NAME OF FATHER <u>Amos Martin</u>	
	11 BIRTHPLACE OF FATHER (State or country) <u>Not Known</u>	
	12 MAIDEN NAME OF MOTHER <u>Naoma Kinton</u>	
13 BIRTHPLACE OF MOTHER (State or country) <u>not known</u>		

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Frank M. Fisher
 (Address) 3610 Elm Ave. Balto Md

15 Filed May 6 1914 Henry G. Neely
 REGISTRAR John Burns & Son

STATE OF MARYLAND
CERTIFICATE OF DEATH

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH May 5, 1914
 (Month) (Day) (Year)
 17 I HEREBY CERTIFY, that I attended deceased from about 23 years to May 5, 1914
 that I last saw him alive on May 3, 1914
 and that death occurred on the date stated above, at 1020 AM
 The CAUSE OF DEATH* was as follows:
Pulmonary Tuberculosis
About (Duration) 7 yrs. mos. ds.
 Contributory (Secondary) None
 (Signed) William J. Todd, M. D.
May 6, 1914 (Address) St. Washington

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.
 Where was disease contracted, if not at place of death?
 Former or usual residence.....

19 PLACE OF BURIAL OR REMOVAL Grand Ridge DATE OF BURIAL May 8/14/1914
 20 UNDERTAKER John Burns & Son ADDRESS Towson

If more blanks are needed, address State Regs. Bldg., 6 E. Franklin St., Balto., Requesting V. S. No. 1.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

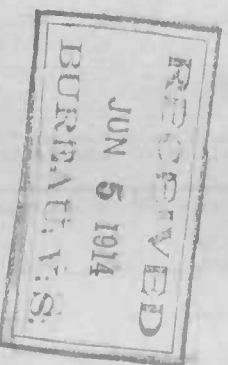
[Approved by U. S. Census and American Public Health Association.]

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Statement of cause of death—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Group"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcin-*

oma, *Sarcoma*, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.*; *Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asphyxia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congential," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and qualify as accidental, suicidal, or homicidal, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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1 PLACE OF DEATH

4668

(120)

STATE OF MARYLAND
CERTIFICATE OF DEATH

County

Baltimore

Village or City

Catonville

(No.)

St.

No.

St.

No.

St.

No.

St.

No.

St.

No.

St.

No.

St.

No.

St.

No.

St.

No.

St.

No.

St.

No.

St.

No.

St.

No.

St.

No.

St.

No.

St.

No.

St.

No.

2 FULL NAME

Edward F. Mason

Registered No.

30

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 SINGLE, MARRIED, WIDOWED, OR DIVORCED

widowed

6 DATE OF BIRTH

April 26, 1838

7 AGE

76 yrs. 0 mos. 20 ds.

If LESS than 1 day, hrs. OR min. ?

8 OCCUPATION

(a) Trade, profession, or particular kind of work.

Oysterman

(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE

(State or country)

Maryland

PARENTS

10 NAME OF FATHER

Hiram Mason

11 BIRTHPLACE OF FATHER

(State or country)

Maryland

12 MAIDEN NAME OF MOTHER

Unknown

13 BIRTHPLACE OF MOTHER

(State or country)

Unknown

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

James Mason

(Address)

Eastport Md

15

Filed

May 25, 1914 Marshall B West

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

May 25, 1914

(Month)

(Day)

(Year)

17

I HEREBY CERTIFY, That I attended deceased from

Apr. 23, 1914, to May 25, 1914.

that I last saw him alive on May 24, 1914.

and that death occurred on the date stated above, at 6:59 a.m.

The CAUSE OF DEATH* was as follows:

Organic Dementia

(Duration) 4 yrs. mos. ds.

Contributory (Secondary)

Chronic Bright's

(Duration) yrs. 1 mos. 2 ds.

(Signed) J. P. Wade, M. D.
May 25, 1914 (Address) Catonsville Md

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death yrs. 1 mos. 2 ds. In the State 76 yrs. mos. ds.

Where was disease contracted, Dec 2 a 60 md

It not at place of death?

Former or usual residence. Dec 2 a 60 md

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Chalk Point Md May 27, 1914

20 UNDERTAKER

ADDRESS

Geo M. Fink 811 N Wolfe

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

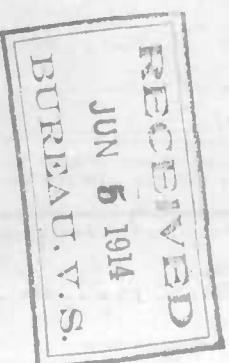
[Approved by U. S. Census and American Public Health Association.]

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Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritonaeum*, etc. *Carcin-*

oma, *Sarcoma*, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congential," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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1 PLACE OF DEATH

4669

County

Balto

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registered No.

38

Village or City

Roland Park

(No.

1053

Falls Road

St.

Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME

Le Roy G. Matther

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 SINGLE,

MARRIED,

WIDOWED,

OR DIVORCED,

(Write the word)

yrs.

6 DATE OF BIRTH

May 21

(Month)

(Day)

1914

7 AGE

1

yrs.

mos.

ds.

If LESS than
1 day, hrs.

OR min. ?

8 OCCUPATION

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE
(State or country)

Baltimore County

PARENTS

10 NAME OF FATHER

Joseph G. Matther

11 BIRTHPLACE OF FATHER
(State or country)

Md.

12 MAIDEN NAME OF MOTHER

Grace Coltrider

13 BIRTHPLACE OF MOTHER
(State or country)

Md.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

Informant:

Joseph G. Matther

(Address)

1053 Falls Road.

15

Filed

May 27

1914

M. J. Porle

REGISTRAR

Deputy Clerk

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

May

26

1914

(Month)

(Day)

(Year)

17

I HEREBY CERTIFY, That I attended deceased from

May 25

1914

to

May 26

1914

that I last saw him alive on May 26, 1914

and that death occurred on the date stated above, at 10 P. M.

The CAUSE OF DEATH* was as follows:

Eating Beef Steer
S.P.
Corrosions Exhaustion
(Duration) yrs. mos. 2 ds.
Contributory I Torain poisoning
(Secondary)
(Duration) yrs. mos. 1 ds.
(Signed) Vernon H. Hill, M.D.
May 27, 1914 (Address) 3705 Falls Road

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, If not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Woodlawn

May 28, 1914

20 UNDERTAKER

ADDRESS

Chenoweth & Chestnut

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

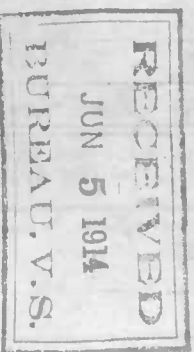
[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer." "Foreman." "Manager." "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not knowingly employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritonaeum*, etc. *Carcin-*

oma, *Sarcoma*, etc., of (name origin: "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic tubular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or concurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Anæmia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congential," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Træmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH

4670

STATE OF MARYLAND
CERTIFICATE OF DEATHCounty BaltimoreRegistration Dist. No. 41Village or City Higglestown (No. 3921 Fair Ave. St.; Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME

Ernest J. Matusky

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White5 SINGLE,
MARRIED,
WIDOWED,
OR DIVORCED
(Write the word)Single

6 DATE OF BIRTH

May 26, 1914
(Month) (Day) (Year)

7 AGE

1 yrs. 1 mos. 1 ds. OR 1 day, 1 hrs. 1 min. ?

8 OCCUPATION

(a) Trade, profession, or particular kind of work

None

(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE

(State or country)

Balto Co.

PARENTS

10 NAME OF FATHER

Ernest J. Matusky

11 BIRTHPLACE OF FATHER

(State or country)

Germany

12 MAIDEN NAME OF MOTHER

Mary F. Wolf

13 BIRTHPLACE OF MOTHER

(State or country)

Balto Co.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Mary F. Matusky

(Address)

3921 Fair Ave

15

Filed

May 28, 1914 W.E. McClaughan

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

May 27, 1914
(Month) (Day) (Year)

17

I HEREBY CERTIFY, That I attended deceased from

May 26, 1914 to May 27, 1914that I last saw him alive on May 26, 1914and that death occurred on the date stated above, at 9:30 P.M.

The CAUSE OF DEATH* was as follows:

Premature Birth(6 mos gestation) (Duration) 6 yrs. 0 mos. 0 ds.

Contributory

Secondary

(Duration) 6 yrs. 0 mos. 0 ds.

(Signed)

C. V. Wiley

M. D.

May 28, 1914 (Address) 1008 Potten Place

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

16 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death 6 yrs. 0 mos. 0 ds. in the State 6 yrs. 0 mos. 0 ds.

Where was disease contracted, If not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Sacred Heart AveMay 28, 1914

20 UNDERTAKER

ADDRESS

Lily Ave403 & 405

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

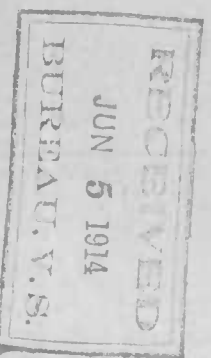
[Approved by U. S. Census and American Public Health Association.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meningis, peritonaeum*, etc., *Carcin-*

oma, Sarcoma, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congential," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Icteric" "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and qualify as ACCIDENTAL, suicidal, or homicidal, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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1 PLACE OF DEATH 4671		STATE OF MARYLAND CERTIFICATE OF DEATH	
County Balto.		Registration Dist. No. 4	
Village or City Highlandtown (No. _____) St. _____ Ward _____		[If death occurred in a hospital or institution, give its NAME instead of street and number.]	
2 FULL NAME Antone Mello			
PERSONAL AND STATISTICAL PARTICULARS			
3 SEX Male	4 COLOR OR RACE White	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) Unknown	
6 DATE OF BIRTH Unknown , 1 _____ (Month) _____ (Day) _____ (Year)			
7 AGE about 55 yrs. _____ mos. _____ ds. OR _____ mln. ?		It LESS than 1 day. _____ hrs.	
8 OCCUPATION (a) Trade, profession, or particular kind of work laborer (b) General nature of industry, business, or establishment in which employed (or employer) Contractors			
9 BIRTHPLACE (State or country) Unknown			
PARENTS	10 NAME OF FATHER Unknown		
	11 BIRTHPLACE OF FATHER (State or country) Unknown		
	12 MAIDEN NAME OF MOTHER Unknown		
	13 BIRTHPLACE OF MOTHER (State or country) Unknown		
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) Harold S. Jones (Address) Robert Jones			
15 Filed May 13, 1914 W. E. McClellan REGISTRAR			
MEDICAL CERTIFICATE OF DEATH			
16 DATE OF DEATH May 12, 1914 (Month) (Day) (Year)			
17 I HEREBY CERTIFY, That I attended deceased from May 12, 1914 that I last saw him alive on _____, 191____ the disease _____			
and that death occurred on the date stated above, at 1 P. m. The CAUSE OF DEATH* was as follows: Dry suffocation caused by a ditch carrying in (Duration) _____ yrs. _____ mos. _____ ds.			
Contributory Secondary (Duration) _____ yrs. _____ mos. _____ ds.			
(Signed) Dean H. Keefe M.D. 512 , 1914 (Address) Paterson Court			
*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.			
18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS) At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds. Where was disease contracted, If not at place of death? _____ Former or usual residence _____			
19 PLACE OF BURIAL OR REMOVAL Hopkins Med Bldg		DATE OF BURIAL 5/13, 1914	
20 UNDERTAKER Chas Crowley		ADDRESS 257 N. Fulton	

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

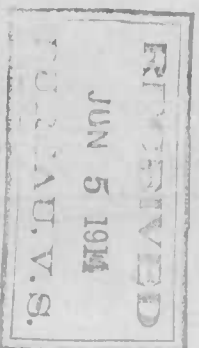
[Approved by U. S. Census and American Public Health Association.]

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Statement of cause of death—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcin-*

oma, Sarcoma, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Insanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicaemia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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1 PLACE OF DEATH 4672
County Baltimore

Village or City Sparks (No. _____ St.; _____ Ward)

2 FULL NAME Florence Eugene Meyers

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No. 37

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE Colored 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) Single

6 DATE OF BIRTH April 5, 1902
(Month) (Day) (Year)

7 AGE 12 yrs. 1 mos. 22 ds. If LESS than 1 day, _____ hrs. OR _____ min. ?

8 OCCUPATION (a) Trade, profession, or particular kind of work none
(b) General nature of industry, business, or establishment in which employed (or employer) _____

9 BIRTHPLACE (State or country) Sparks Md

10 NAME OF FATHER Albert E Meyers

11 BIRTHPLACE OF FATHER (State or country) Sparks Md

12 MAIDEN NAME OF MOTHER Lucy H. Powells

13 BIRTHPLACE OF MOTHER (State or country) Sparks

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Lucy H. Powells
(Address) Cockeysville Md

15 Filed May 27, 1914 J. A. Drach REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH May 27, 1914
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from Feb 3, 1914 to May 27th, 1914

that I last saw her alive on May 24, 1914

and that death occurred on the date stated above, at 7 A. m.

The CAUSE OF DEATH* was as follows:

Typhoid Mesenterica with secondary infection of lungs

(Duration) 2 yrs. _____ mos. _____ ds.

Contributory General Inanition
Secondary want of nourishment (Duration) 2 yrs. _____ mos. _____ ds.

(Signed) J. A. Drach, M. D.
May 27, 1914 (Address) Cockeysville Md

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR REGENT RESIDENTS)

At place of death _____ yrs. _____ mos. _____ ds. in the State _____ yrs. _____ mos. _____ ds.

Where was disease contracted, If not at place of death? _____

Former or usual residence _____

19 PLACE OF BURIAL OR REMOVAL Quaker Bottom Cemetery DATE OF BURIAL May 29, 1914

20 UNDERTAKER J. C. Brooks ADDRESS Sparks Md

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

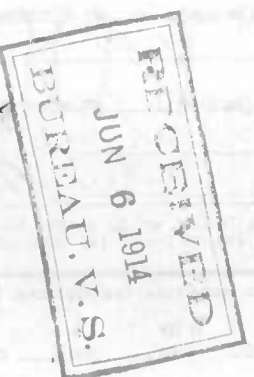
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1 PLACE OF DEATH

4673

County BaltimoreVillage or City Catonville (No. Frederick 24)

St.; Ward)

STATE OF MARYLAND
CERTIFICATE OF DEATHRegistration Dist. No. 30

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME John Theobald Milburn

PERSONAL AND STATISTICAL PARTICULARS

3 SEX <u>Male</u>	4 COLOR OR RACE <u>White</u>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) <u>Single</u>
6 DATE OF BIRTH <u>April 30</u> , 18 <u>84</u> (Month) (Day) (Year)		
7 AGE <u>90</u> yrs. <u>2</u> mos. <u>20</u> ds.		If LESS than 1 day, hrs. OR min. ?

8 OCCUPATION
(a) Trade, profession, or particular kind of work Pilot. (Retired)
(b) General nature of industry, business, or establishment in which employed (or employer) _____

9 BIRTHPLACE (State or country) St. Mary's Co Maryland

PARENTS	10 NAME OF FATHER <u>John Milburn</u>
	11 BIRTHPLACE OF FATHER (State or country) <u>St. Mary's Maryland</u>
	12 MAIDEN NAME OF MOTHER <u>Mary Theobald</u>
	13 BIRTHPLACE OF MOTHER (State or country) <u>St. Mary's Co Maryland</u>

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Wm. H. Myers(Address) Catonville Md15 Filed May 24 1914 Marshall B West

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH May 20, 1914
(Month) (Day) (Year)17 I HEREBY CERTIFY, That I attended deceased from August 1st 1913, to May 20th 1914.that I last saw him alive on May 20th 1914and that death occurred on the date stated above, at 8:45 a.m.

The CAUSE OF DEATH* was as follows:

Information of old age.
Arteriosclerosis and
Myocarditis (Duration) 10 yrs. — mos. — ds.
Contributory lack of exercise
Secondary and Exhaustion (Duration) — yrs. — mos. — ds.

(Signed) J. Chas. Russell, M. D.
May 20th 1914 (Address) Catonville Md

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, If not at place of death?

Former or usual residence _____

19 PLACE OF BURIAL OR REMOVAL London Park Cemetery DATE OF BURIAL May 25 191420 UNDERTAKER A. E. Hughes ADDRESS 17 S. Broadway

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcin-*

oma, Sarcoma, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile" etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Tremor," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal *septicæmia*," "Puerperal *peritonitis*," etc. State cause for which surgical operation was undertaken. For violent DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Reverber wound of head—homicide*; *Poisoned by carboic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

RECEIVED
JUN 5 1914
BUREAU V. V. S.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH 4674

County BaltimoreVillage or City Gardenville (No. _____, St.; Ward _____)

120
STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No. 43

[If death occurred in
a hospital or institution,
give its NAME instead
of street and number.]

2 FULL NAME Rosa Milchling

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) Single

6 DATE OF BIRTH 3 29 1877
(Month) (Day) (Year)

7 AGE 27 yrs. 1 mos. 22 ds. OR LESS than 1 day, _____ hrs. _____ min. ?

8 OCCUPATION

(a) Trade, profession, or particular kind of work House Keeper(b) General nature of industry, business, or establishment in which employed (or employer) None9 BIRTHPLACE (State or country) Maryland

10 NAME OF FATHER Christian Milchling
11 BIRTHPLACE OF FATHER (State or country) Europe

12 MAIDEN NAME OF MOTHER Catharine Engel
13 BIRTHPLACE OF MOTHER (State or country) Maryland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) J. Henry Herman

(Address) _____

15 Filed May 24 1914 W. H. Clay
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH 5 31 1914
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from May 1st 1914 to May 31 1914,
that I last saw her alive on 5 30 Pm 1914

and that death occurred on the date stated above, at 5 30 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis, Valvular disease of heart, with dropsy
(Duration) _____ yrs. _____ mos. _____ ds.

Contributory

Chronic Nephritis (Duration) _____ yrs. _____ mos. _____ ds.
(Signed) W. H. Clay, M. D.
May 23 1914 (Address) Gardenville

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL Jerusalem Cemetery DATE OF BURIAL May 24th 1914

20 UNDERTAKER Frederick Lassech & Sons ADDRESS Fullerton Road

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

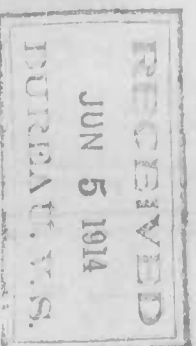
[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcin-*

oma, Sarcoma, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congestial," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL *septicæmia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For violent DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, suicidal, or homicidal, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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1 PLACE OF DEATH

46754

County Baltimore

78
STATE OF MARYLAND
CERTIFICATE OF DEATH

Registered No. 32Village or City Mt. Washington (No. Greenspring Ave. St. Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME Emma Miles

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE Colord 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) Married

6 DATE OF BIRTH Mar. 4, 1868
(Month) (Day) (Year)

7 AGE 46 yrs. 2 mos. 21 ds. If LESS than 1 day, hrs. OR min.?

8 OCCUPATION

(a) Trade, profession, or particular kind of work House keeper(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE (State or country)

Baltimore City

PARENTS

10 NAME OF FATHER Not Known11 BIRTHPLACE OF FATHER (State or country) " "12 MAIDEN NAME OF MOTHER Emma Brown13 BIRTHPLACE OF MOTHER (State or country) Balto. City

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Charles Miles(Address) Greenspring Ave,

15

Filed May 27, 1914 H. H. Taylor
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH 5 26, 1914
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from Jan. 2, 1914 to May 15, 1914, that I last saw her alive on May 24, 1914

and that death occurred on the date stated above, at 8 P m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis(Duration) 1 yrs. 6 mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) C. H. Beeton, M. D.
5-26, 1914 (Address) Mt Washington

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death? Former or usual residence

19 PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

St John Church May 27, 1914

20 UNDERTAKER H. S. Marshall 3539 Fall Road ADDRESS

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

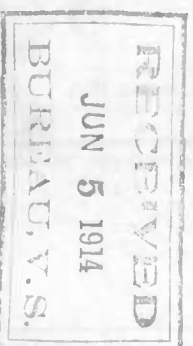
[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Composer*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritonaeum*, etc. *Carcin-*

oma, *Sarcoma*, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Anemia," "Anasemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For violent DEATHS state MEANS OF INJURY and quality as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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1 PLACE OF DEATH 4676

County BaltimoreVillage or City Highlandtown (No. 1540, S., 1st St.; — Ward)STATE OF MARYLAND
CERTIFICATE OF DEATHRegistration Dist. No. 41

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME

Chas. James Richard Miller

PERSONAL AND STATISTICAL PARTICULARS

3 SEX male 4 COLOR OR RACE white 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED single
(Write the word)

6 DATE OF BIRTH April 28, 1914
(Month) (Day) (Year)7 AGE — yrs. — mos. 27 ds. It LESS than 1 day, — hrs. OR — min. ?

8 OCCUPATION
(a) Trade, profession, or particular kind of work none
(b) General nature of industry, business, or establishment in which employed (or employer) (Infant)

9 BIRTHPLACE (State or country) Balt Co. Md.10 NAME OF FATHER Charles R. S. Miller11 BIRTHPLACE OF FATHER (State or country) Balto Md.12 MAIDEN NAME OF MOTHER Della Duffy13 BIRTHPLACE OF MOTHER (State or country) Pittsburg Pa.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Chas. R. S. Miller(Address) 1540 S. 1st St.15 Filed May 26, 1914 W. E. McLaughlin
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH May 25, 1914
(Month) (Day) (Year)17 I HEREBY CERTIFY, That I attended deceased from May 20, 1914, to May 25, 1914.that I last saw him alive on May 24, 1914.and that death occurred on the date stated above, at 8:30 p.m.

The CAUSE OF DEATH* was as follows:

Exhaustion(Duration) — yrs. 3 mos. — ds.Contributory
SecondaryMal nutrition(Duration) — yrs. 14 mos. — ds.(Signed) A. M. Wright, M. D.May 26, 1914 (Address) Edmund and Dimes St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death — yrs. — mos. — ds. In the State — yrs. — mos. — ds.

Where was disease contracted, If not at place of death?

Former or usual residence —19 PLACE OF BURIAL OR REMOVAL Schwartz's Ceme. DATE OF BURIAL May 26, 191420 UNDERTAKER Chas. Crowley. ADDRESS 25-17 Fulton

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

Am.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

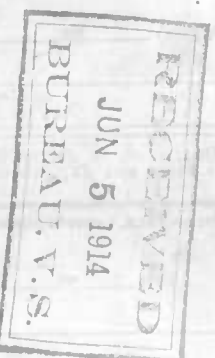
[Approved by U. S. Census and American Public Health Association.]

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Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcin-*

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1 PLACE OF DEATH

4677

County BaltimoreVillage or City Eudowood Sanatorium, Towson, Md. (No. _____, St.; _____ Ward)STATE OF MARYLAND
CERTIFICATE OF DEATHRegistration Dist. No. 98

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME

Winifred C. Morse

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White5 SINGLE,
MARRIED,
WIDOWED,
OR DIVORCED
(Write the word)Married

6 DATE OF BIRTH

March 17, 1886
(Month) (Day) (Year)

7 AGE

28 yrs. 1 mos. 26 ds. If LESS than
1 day, _____ hrs. OR _____ min. ?

8 OCCUPATION

(a) Trade, profession, or particular kind of work

Domestic

(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE

(State or country)

Catonsville, Md.

10 NAME OF FATHER

George Pilert

PARENTS

11 BIRTHPLACE OF FATHER
(State or country)Catonsville, Md.

12 MAIDEN NAME OF MOTHER

Mary C. Spielman13 BIRTHPLACE OF MOTHER
(State or country)Baltimore, Md.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Geo. Pilert

(Address)

Paradise Catonsville

15

Filed 8/10, 1914Clara Smith

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

May 12, 1914
(Month) (Day) (Year)17 I HEREBY CERTIFY, That I attended deceased from March 26, 1914 to May 12, 1914that I last saw her alive on May 12, 1914and that death occurred on the date stated above, at 5:12 p.m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis(Duration) 12 yrs. — mos. — ds.Contributory
Secondary

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed)

Martin F. Sloan, M. D.May 12, 1914 (Address) Eudowood Towson, Md.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death _____ yrs. 1 mos. 16 ds. In the State 28 yrs. 1 mos. 26 ds.

Where was disease contracted,

If not at place of death?

Former or usual residence Berkeley Springs, W. Va.

19 PLACE OF BURIAL OR REMOVAL

New Cathedral Cem

DATE OF BURIAL

May 15, 1914

20 UNDERTAKER

William Coak

ADDRESS

Bulto, Md.

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcin-*

oma, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report more symptoms or terminal conditions, such as "As-thenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congential," "Senile" etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Tremor," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septichæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

RECEIVED

JUN 5 1914

BUREAU, U. S.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH

4678

County Balto.Village or City Canton(No. 1310 S. 2nd

St; Ward)

Registered No. 41

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME

Still Birth of Thomas E. + Bertha Mullaney

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White

5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word)

single

6 DATE OF BIRTH

May 22nd, 1914
(Month) (Day) (Year)

7 AGE

Still Birth yrs. 0 mos. 0 ds.

If LESS than 1 day, hrs. min. ?

8 OCCUPATION

(a) Trade, profession, or particular kind of work.

none

(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE (State or country)

Balto. Co. Md.

PARENTS

10 NAME OF FATHER

Thomas E. Mullaney

11 BIRTHPLACE OF FATHER (State or country)

Balto. Md.

12 MAIDEN NAME OF MOTHER

Bertha M. McCormick

13 BIRTHPLACE OF MOTHER (State or country)

Balto. Md.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Thomas E. Mullaney

(Address)

1310 S. 2nd St. Balto. Co.

15

Filed

May 23, 1914 W. E. McClaughon

REGISTRAR

STATE OF MARYLAND
CERTIFICATE OF DEATH

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

May 22, 1914
(Month) (Day) (Year)

17

I HEREBY CERTIFY, that I attended deceased from

May 22, 1914, to May 22, 1914that I last saw him alive on May 22, 1914and that death occurred on the date stated above, at 7:45 p. m.

The CAUSE OF DEATH* was as follows:

Still Birth 5 Mos.
Utero-Gestation (Duration) yrs. mos. ds.

Contributory (Secondary)

Unknown(Signed) M. J. McAvoy, M. D.
May 23, 1914 (Address) 839 S. Ellenwood

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Sacred Heart Cem. May 23rd, 1914

20 UNDERTAKER

ADDRESS

Lilly & Zeller 403 S. Wolfe St.

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

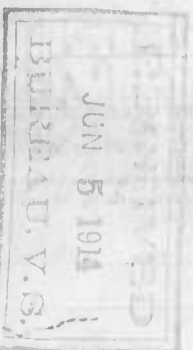
[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcin-*

oma, *Sarcoma*, etc., of ----- (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congential," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such. If impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.



WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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1 PLACE OF DEATH

County BaltimoreVillage or City Cowson Md. (No. 64 E. Deane Ave St.; Ward)Registered No. 38

[It death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME Mary Murphy

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

female

4 COLOR OR RACE

white

5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word)

Single

6 DATE OF BIRTH

May 17, 1889
(Month) (Day) (Year)

7 AGE

45 yrs. 0 mos. 0 ds. OR 1 day, 0 hrs. 0 min. ?

8 OCCUPATION

(a) Trade, profession, or particular kind of work

None

(b) General nature of industry, business, or establishment in which employed (or employer)

None

9 BIRTHPLACE (State or country)

U.S.

10 NAME OF FATHER

David Murphy

11 BIRTHPLACE OF FATHER (State or country)

Ireland

12 MAIDEN NAME OF MOTHER

Mary Cronin

13 BIRTHPLACE OF MOTHER (State or country)

Ireland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Kate Cronin

(Address)

Townson Rd.

15

Filed

May 20, 1914

Clara Dwyer

REGISTRAR

STATE OF MARYLAND
CERTIFICATE OF DEATH

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

May 17, 1914
(Month) (Day) (Year)

17 I HEREBY CERTIFY That I attended deceased from

May 17, 1914, to May 17, 1914
that I last saw him alive on at Fall, 191and that death occurred on the date stated above, at 10 a. m.

The CAUSE OF DEATH* was as follows:

Apoplexyfew hours (Duration) 0 yrs. 0 mos. 0 ds.

Contributory (Secondary)

Arterio sclerosis(Duration) 2 yrs. 0 mos. 0 ds.(Signed) Dr. Royce S. Dwyer, M. D.May 17, 1914 (Address) Cowson Md.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death 0 yrs. 0 mos. 0 ds. In the State 0 yrs. 0 mos. 0 ds.

Where was disease contracted, If not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

St Marys Roman May 17, 1914

20 UNDERTAKER

ADDRESS

Prof. Fahey & Son 1318 Light St.

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

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Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc.. *Carcin-*

oma, *Sarcoma*, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 10 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congential," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state MEANS OF INJURY and quality as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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RECEIVED

JUN 5 1914

BUREAU, V. S.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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1 PLACE OF DEATH Balto.			4680			STATE OF MARYLAND 146 CERTIFICATE OF DEATH		
County			Village or City			Registration Dist. No. 30		
2 FULL NAME Andrew Raymond Myers			St.; Ward			[It death occurred in a hospital or institution, give its NAME instead of street and number.]		
PERSONAL AND STATISTICAL PARTICULARS								
3 SEX male	4 COLOR OR RACE White	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) Single						
6 DATE OF BIRTH February 17, 1900		16 DATE OF DEATH May 9, 1914						
(Month) (Day) (Year)		(Month) (Day) (Year)						
7 AGE 14 yrs. 7 mos. 22 ds.	If LESS than 1 day, hrs. OR min. ?							
8 OCCUPATION (a) Trade, profession, or particular kind of work (b) General nature of industry, business, or establishment in which employed (or employer) At Bookcase								
9 BIRTHPLACE (State or country) Va								
PARENTS	10 NAME OF FATHER Theo. S. Myers							
	11 BIRTHPLACE OF FATHER (State or country) Va							
	12 MAIDEN NAME OF MOTHER Mora E. Reilly							
	13 BIRTHPLACE OF MOTHER (State or country) Va							
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) Mora E. Myers (Address) Mt Reimier Rd								
15 Filed _____, 1914 REGISTRAR								
MEDICAL CERTIFICATE OF DEATH								
16 DATE OF DEATH May 9, 1914 (Month) (Day) (Year)								
17 I HEREBY CERTIFY, That I attended deceased from July 26, 1914, to May 9, 1914, that I last saw him alive on May 9, 1914, and that death occurred on the date stated above, at 4 a. m. The CAUSE OF DEATH* was as follows: Mastoiditis (Duration) yrs. mos. 12 ds. Contributory meninges Secondary (Duration) yrs. mos. 4 ds. (Signed) W. S. Rublett, M. D. , 1914 (Address) Hilldale								
*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.								
18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS) At place of death yrs. mos. ds. In the State yrs. mos. ds. Where was disease contracted, If not at place of death? Former or usual residence								
19 PLACE OF BURIAL OR REMOVAL Brentwood Rd					DATE OF BURIAL May 11, 1914			
20 UNDERTAKER William Cook					ADDRESS Baltimore			

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

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Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meningis, peritoneum*, etc., *Carcin-*

oma, Sarcoma, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicaemia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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RECEIVED
JUN 5 1914
BUREAU, V.S.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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1 PLACE OF DEATH

4681

County

Baltimore

Village or City

Harrisonville

(No.

St.

Ward)

Registration Dist. No.

131

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME

Joseph Earl

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

male

4 COLOR OR RACE

Black

5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word)

Single

6 DATE OF BIRTH

Jan

13

1887

(Month)

(Day)

(Year)

7 AGE

27

yrs.

3

mos.

20

ds.

or LESS than 1 day, hrs. or min. ?

8 OCCUPATION

(a) Trade, profession, or particular kind of work

Laborer in stone quarry

(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE

(State or country)

Maryland

PARENTS

10 NAME OF FATHER

Henry Earl

11 BIRTHPLACE OF FATHER

(State or country)

Virginia

12 MAIDEN NAME OF MOTHER

Rachel Bell

13 BIRTHPLACE OF MOTHER

(State or country)

Maryland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Frank Wacey

(Address)

Rocky, Md.

15

Filed

May 6, 1914

H. J. Slope

REGISTRAR

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

STATE OF MARYLAND
CERTIFICATE OF DEATH

78

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

May

6

1914

(Month)

(Day)

(Year)

17

I HEREBY CERTIFY, That I attended deceased from

Mar. 4, 1914

to

May 6, 1914

that I last saw him alive on

May 5, 1914

and that death occurred on the date stated above, at 10:30 A.M.

The CAUSE OF DEATH* was as follows:

Tuberculosis of Lungs

(Duration)

3

yrs.

mos.

ds.

Contributory

Secondary

(Duration)

yrs.

mos.

ds.

(Signed)

Wm. E. Martey

M. D.

May 6, 1914

(Address)

Rocky, Md.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place

of death

yrs.

mos.

ds.

In the

State

yrs.

mos.

ds.

Where was disease contracted, if not at place of death?

Former or

usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Cherry Hill Cemetery

May 7, 1914

20 UNDERTAKER

ADDRESS

J. H. Kraft

Pikesville

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

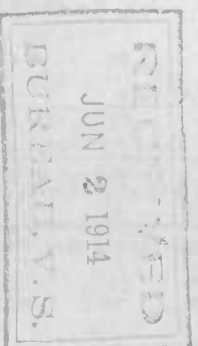
[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Composer*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcin-*

oma, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Colapsus," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL *septicæmia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For violent DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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1 PLACE OF DEATH 4682
County Baltimore

Village or City White Hall (No. 1) Maryland

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No. 36

St.; Ward

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME Lottie C. Nelson

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) Married

6 DATE OF BIRTH Nov 12, 1867
(Month) (Day) (Year)

7 AGE 46 yrs. 7 mos. ds. If LESS than 1 day,.....hrs. OR.....min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer) Housework

9 BIRTHPLACE (State or country) Maryland

10 NAME OF FATHER Shadrach Street

11 BIRTHPLACE OF FATHER (State or country) Hanford Co.

12 MAIDEN NAME OF MOTHER Rachel J. Enser

13 BIRTHPLACE OF MOTHER (State or country) Baltimore Co.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Maggie S. Bowman

(Address) 334 Federal St. Balto., Md.

15 Filled May 27, 1914 W. H. Jones M.D.
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH May 21st, 1914
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from May 16th, 1914, to May 21st, 1914
that I last saw her alive on May 21st, 1914

and that death occurred on the date stated above, at 5:30 a.m.

The CAUSE OF DEATH* was as follows:

Diabetes Mellitus

(Duration) 3 yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) Wilbur Bostner, M. D.
May 23rd, 1914 (Address) White Hall Md

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL DATE OF BURIAL
Vernon M. E. Cemetery May 24, 1914

20 UNDERTAKER ADDRESS
P. Markstone & Son White Hall Md

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

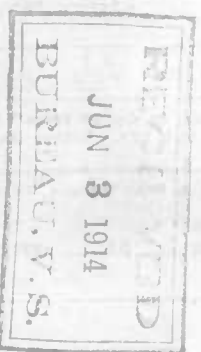
[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative wealthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Plaster, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry; and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Scrub, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Group"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc.. *Carcin-*

oma, Sarcoma, etc., of _____ (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles, Whooping cough, Chronic valvular heart disease, Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.*; *Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congential," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state MEANS OF INJURY and quality as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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1 PLACE OF DEATH		4683		105		STATE OF MARYLAND CERTIFICATE OF DEATH	
County		Baltimore		Registration Dist. No.		41	
Village or City		Highlandtown		No. 417 S. Highland Ave.		St. Ward	
2 FULL NAME		Margareth Nitzel					
PERSONAL AND STATISTICAL PARTICULARS							
3 SEX		4 COLOR OR RACE		5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word)			
Female		White		Widow			
6 DATE OF BIRTH		July 16, 1838					
7 AGE		75 yrs. 10 mos. 7 ds. It LESS than 1 day, hrs. OR min. ?					
8 OCCUPATION		Housework					
9 BIRTHPLACE (State or country)		Germany					
PARENTS	10 NAME OF FATHER		Unknown				
	11 BIRTHPLACE OF FATHER (State or country)		Germany				
	12 MAIDEN NAME OF MOTHER		Unknown				
13 BIRTHPLACE OF MOTHER (State or country)		Germany					
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE							
Informant		Geo. Nitzel					
(Address)		417 S. Highland					
15		May 25, 1914 W.E. McClanahan					
Filed		REGISTRAR					
MEDICAL CERTIFICATE OF DEATH							
16 DATE OF DEATH		May 23, 1914					
17		I HEREBY CERTIFY, That I attended deceased from April 29, 1914, to May 23, 1914, that I last saw her alive on May 22, 1914, and that death occurred on the date stated above, at 7:30 a.m.					
The CAUSE OF DEATH* was as follows:		Enteritis					
Contributory (Secondary)		Cardiac dilatation					
(Signed)		E. J. Britton, M. D.					
May 24, 1914		(Address) 1711 E. Baltimore St.					
*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.							
18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)							
At place of death		yrs. mos. ds.		In the State		yrs. mos. ds.	
Where was disease contracted, if not at place of death?							
Former or usual residence							
19 PLACE OF BURIAL OR REMOVAL		Oak Lawn					
20 UNDERTAKER		Philip Herwig Orleans St.					
DATE OF BURIAL		May 26, 1914					
ADDRESS		2016					
If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.							

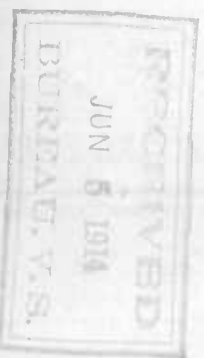
REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

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Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc.. *Carcinoma*, *Sarcoma*, etc., of _____ (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asphyxia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and quality as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such. If impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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1 PLACE OF DEATH **4684**
County Baltimore

Village or City Parkton (No. _____, St.; _____ Ward)

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No. 26

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME Dr. Robert R. Norris

PERSONAL AND STATISTICAL PARTICULARS

3 SEX male 4 COLOR OR RACE white 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) single

6 DATE OF BIRTH April 11, 1851
(Month) (Day) (Year)

7 AGE 63 yrs. 1 mos. 12 ds. If LESS than 1 day, ____ hrs. OR ____ min. ?

8 OCCUPATION
(a) Trade, profession, or particular kind of work M. D.
(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE (State or country) md.

10 NAME OF FATHER John S. Norris

11 BIRTHPLACE OF FATHER (State or country) md.

12 MAIDEN NAME OF MOTHER Amanda G. Hutchins

13 BIRTHPLACE OF MOTHER (State or country) md.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) J. Wiley Norris

(Address) Norrisville Rayford les md

15 Filed May 24, 1914 W. H. Byrd REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH May 23, 1914
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from May 23, 8:50 a.m., 1914, to May 23, 1914, that I last saw him alive on May 23, 1914

and that death occurred on the date stated above, at 8:50 P.M.

The CAUSE OF DEATH* was as follows:

Diabetes Mellitus

(Duration) ____ yrs. ____ mos. ____ ds.

Contributory (Secondary) Angina pectoris

(Duration) 25 minutes

(Signed) W. H. Byrd, M. D.

May 24, 1914 (Address) Parkton Md

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ____ yrs. ____ mos. ____ ds. In the State ____ yrs. ____ mos. ____ ds.

Where was disease contracted, If not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Norrisville Cemetery May 26, 1914

20 UNDERTAKER ADDRESS

O. Leroy Stiffler Parkton Md

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

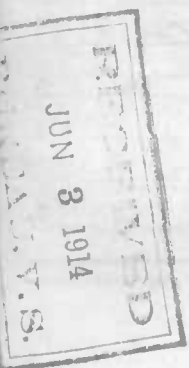
[Approved by U. S. Census and American Public Health Association.]

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Statement of cause of death—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc. *Carcin-*

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1 PLACE OF DEATH County <u>Baltimore</u>		4685	28		STATE OF MARYLAND CERTIFICATE OF DEATH	
Village or City <u>Westport</u>		(No. _____)	St. _____		Ward _____	
2 FULL NAME <u>Henry Ogel</u>		Registration Dist. No. <u>72</u>				
PERSONAL AND STATISTICAL PARTICULARS						
3 SEX <u>Male</u>	4 COLOR OR RACE <u>Colored</u>	5 SINGLE, MARRIED, WIDDED, OR DIVORCED <u>Single</u> (Write the word)				
6 DATE OF BIRTH <u>unknown</u> , 1881						
(Month) _____ (Day) _____ (Year) _____						
7 AGE <u>34</u> yrs. <u>unknown</u> mos. <u>unknown</u> ds. <u>OR</u> <u>unknown</u> min. ?		If LESS than 1 day, _____ hrs.				
8 OCCUPATION (a) Trade, profession, or particular kind of work <u>Laborer.</u> (b) General nature of industry, business, or establishment in which employed (or employer)						
9 BIRTHPLACE (State or country) <u>md.</u>						
PARENTS	10 NAME OF FATHER <u>John Ogel</u>					
	11 BIRTHPLACE OF FATHER (State or country) <u>md.</u>					
	12 MAIDEN NAME OF MOTHER <u>Mary Dapris</u>					
	13 BIRTHPLACE OF MOTHER (State or country) <u>md.</u>					
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE						
(Informant) <u>Henry Ogel</u>						
(Address) <u>Westport</u>						
15 Filed <u>May 15</u> , 191 <u>4</u> <u>L. H. Ruhl</u> REGISTRAR						
MEDICAL CERTIFICATE OF DEATH						
16 DATE OF DEATH <u>May</u> , 14, 191 <u>4</u> (Month) _____ (Day) _____ (Year) _____						
17 I HEREBY CERTIFY, That I attended deceased from <u>May 14</u> , 191 <u>4</u> , to <u>May 15</u> , 191 <u>4</u> , that I last saw him alive on <u>May 15</u> , 191 <u>4</u> , and that death occurred on the date stated above, at <u>4 p. m.</u> , The CAUSE OF DEATH* was as follows: <u>Tuberculosis of Lungs</u> (Duration) _____ yrs. <u>6</u> mos. _____ ds. Contributory <u>By pneumonia</u> (Duration) _____ yrs. _____ mos. <u>4</u> ds. (Signed) <u>Ruehlant</u> , M. D. <u>May 14</u> , 191 <u>4</u> (Address) <u>unknown</u>						
*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.						
18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS) At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds. Where was disease contracted, If not at place of death? _____ Former or usual residence _____						
19 PLACE OF BURIAL OR REMOVAL <u>Mt Auburn</u>				DATE OF BURIAL <u>May 17</u> , 191 <u>4</u>		
20 UNDERTAKER <u>Geo. H. Hooper</u>				ADDRESS <u>Balto. Md.</u>		

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Plumber*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tubercles of lungs*, *meninges*, *peritoneum*, etc., *Carcin-*

oma, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-theia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Traemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal, septicæmia," "Puerperal peritonitis," etc. State cause for violent surgical operation was undertaken. For violent deaths state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

RECEIVED
JUN 4 1914
BUREAU, U. S.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

' PLACE OF DEATH 4686
County Baltimore

Village or City Rogersville (No. 403 Walnut Ave., St.; Ward) Registration Dist. No. 30

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

* FULL NAME Mrs Sarah Owens

PERSONAL AND STATISTICAL PARTICULARS

3 SEX <u>Female</u>	4 COLOR OR RACE <u>White</u>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) <u>Married</u>
6 DATE OF BIRTH <u>Unknown</u> (Month) (Day) (Year)		
7 AGE <u>77</u> yrs. mos. ds.		If LESS than 1 day, hrs. OR min. ?
8 OCCUPATION (a) Trade, profession, or particular kind of work <u>Housewife</u> (b) General nature of industry, business, or establishment in which employed (or employer)		
9 BIRTHPLACE (State or country) <u>Baltimore, Md.</u>		

PARENTS

10 NAME OF FATHER <u>David McComick</u>
11 BIRTHPLACE OF FATHER (State or country) <u>Ireland</u>
12 MAIDEN NAME OF MOTHER <u>Rebecca</u>
13 BIRTHPLACE OF MOTHER (State or country) <u>Ireland</u>

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs F. M. M.

(Address) 1109 N. Shuster St. Balto

15 Filed May 21, 1914 Marshall B. West
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH May 20, 1914
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from May 19, 1914, to May 20, 1914, that I last saw him alive on May 20, 1914.

and that death occurred on the date stated above, at 225 P. m.
The CAUSE OF DEATH* was as follows:

Chronic Intestinal Septicemia
with Degeneration of the Stomach
(Duration) yrs. mos. ds.

Contributory
(Secondary)

(Signed) Herbert M. Munn, M. D.
May 21, 1914 (Address) Cleasville, Md.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.
Where was disease contracted,
If not at place of death?
Former or usual residence.

19 PLACE OF BURIAL OR REMOVAL <u>Greenmount Cem</u>	DATE OF BURIAL <u>May 22</u> , 191 <u>4</u>
20 UNDERTAKER <u>W. J. McInerney & Son</u>	ADDRESS <u>Pennock Rath</u>

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

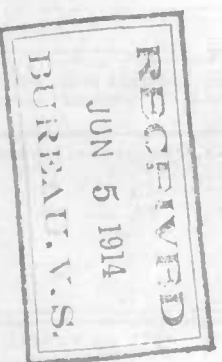
[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative wealthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Plumber*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritonaeum*, etc. *Carcin-*

oma, *Sarcoma*, etc., of _____ (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 10 d.; *Bronchopneumonia* (secondary), 10 d. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congential," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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1 PLACE OF DEATH

4687

County

Baltimore

 STATE OF MARYLAND
 CERTIFICATE OF DEATH

Registration Dist. No.

41

Village or City

Highland

(No. 414)

5th

St.; Ward)

 [If death occurred in
 a hospital or institution,
 give its NAME instead
 of street and number.]

2 FULL NAME

Fred. Paul

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

W

5 SINGLE,
MARRIED,
WIDOWED,
ORDIVORCED
(Write the word)

Single

8 DATE OF BIRTH

Unknown

(Month) (Day) (Year)

7 AGE

Unknown

If LESS than
1 day, hrs.
yrs. mos. ds. OR min. ?

9 OCCUPATION

(a) Trade, profession, or
particular kind of work(b) General nature of industry,
business, or establishment in
which employed (or employer)

Daily Laborer

9 BIRTHPLACE

(State or country)

Md

PARENTS

10 NAME OF
FATHER

Unknown

11 BIRTHPLACE
OF FATHER
(State or country)

Unknown

12 MAIDEN NAME
OF MOTHER

Unknown

13 BIRTHPLACE
OF MOTHER
(State or country)

Unknown

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

None

(Address)

15

Filed May 19, 1914

W. E. McLaughlin

REGISTRAR

19 PLACE OF BURIAL OR REMOVAL

Unknown

DATE OF BURIAL

May 19, 1914

20 UNDERTAKER

Christians Miller

ADDRESS

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

May 19, 1914

(Month) (Day) (Year)

17

I HEREBY CERTIFY, That I attended deceased from

, 191, to , 191,

that I last saw h..... alive on , 191

and that death occurred on the date stated above, at m,

The CAUSE OF DEATH* was as follows:

Alcoholism

(Duration) yrs. mos. ds.

Contributory
Secondary

(Duration) yrs. mos. ds.

(Signed)

A. J. Miller, M. D.

May 19, 1914 (Address)

Corner

 *State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT
 CASES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL,
 SUICIDAL, or HOMICIDAL.
18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS,
OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted,
if not at place of death?Former or
usual residence

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

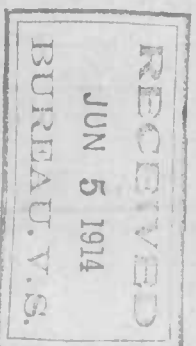
[Approved by U. S. Census and American Public Health Association.]

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Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcin-*

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1 PLACE OF DEATH

4688

120

STATE OF MARYLAND
CERTIFICATE OF DEATHCounty BaltimoreRegistration Dist. No. 44Village or City Highlandtown (No. 3217 Foster Ave. St.; Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME

Victoria Pfeifer

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) Widow

6 DATE OF BIRTH Aug. 15th, 1885
(Month) (Day) (Year)

7 AGE 78 yrs. 8 mos. 21 ds. OR LESS than 1 day.....hrs. OR.....min. ?

8 OCCUPATION
(a) Trade, profession, or particular kind of work Housework
(b) General nature of industry, business, or establishment in which employed (or employer) At Home

9 BIRTHPLACE (State or country) Germany

10 NAME OF FATHER A. Marce

11 BIRTHPLACE OF FATHER (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (State or country) Germany

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Frank Pfeifer(Address) 3217 Foster Ave.

15 Filed May 9th, 1914 W. E. McCloud
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH May 6, 1914
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from April 25, 1914, to May 6, 1914.

that I last saw he alive on May 6, 1914.

and that death occurred on the date stated above, at 11.40 A. M.

The CAUSE OF DEATH* was as follows:

Chronic Intestinal Catarrh

(Duration) 6 yrs. 6 mos. 6 ds.

Contributory Senility
Secondary

(Duration) 6 yrs. 6 mos. 6 ds.

(Signed) W. E. McCloud, M. D.

May 6, 1914. (Address) 619 S. Clinton St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death 6 yrs. 6 mos. 6 ds. In the State 6 yrs. 6 mos. 6 ds.

Where was disease contracted, If not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL Sacred Heart Cem. DATE OF BURIAL May 9, 1914

20 UNDERTAKER W. L. Lill and Zeiler ADDRESS 403 S. Wolfe St.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

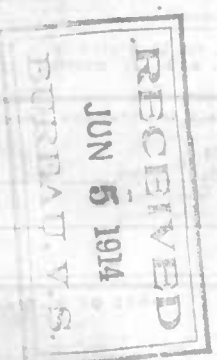
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Statement of cause of death—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritonaeum*, etc., *Carcin-*

oma, Sarcoma, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congential," "Senile" etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and qualify as ACCIDENTAL, suicidal, or homicidal, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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1 PLACE OF DEATH

4689

 STATE OF MARYLAND
 CERTIFICATE OF DEATH
County Balto.Registered No. 41
 Village or City Highlandtown (No. 224) Clinton St.; Ward)

 [If death occurred in
 a hospital or institution,
 give its NAME instead
 of street and number.]
2 FULL NAME William H. Pittinger

PERSONAL AND STATISTICAL PARTICULARS

 3 SEX Male 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Married
 (Write the word)

 6 DATE OF BIRTH Oct. 29th, 1874
 (Month) (Day) (Year)

 7 AGE 40 yrs. 6 mos. 5 ds. If LESS than 1 day, hrs. OR min. ?

 8 OCCUPATION
 (a) Trade, profession, or particular kind of work Clerk in
 (b) General nature of industry, business, or establishment in which employed (or employer) Shirt Factory

 9 BIRTHPLACE (State or country) Balto. Md.

 10 NAME OF FATHER Richard V. Pittinger

 11 BIRTHPLACE OF FATHER (State or country) Balto. Md.

 12 MAIDEN NAME OF MOTHER Mary E. Garrett

 13 BIRTHPLACE OF MOTHER (State or country) Balto. Md.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

 (Informant) Richard V. Pittinger
 (Address) 533 N. Luzerne St.

 15 May 4, 1914 W. E. McLaughlin
 Filed REGISTRAR

MEDICAL CERTIFICATE OF DEATH

 16 DATE OF DEATH May 3rd, 1914
 (Month) (Day) (Year)

 17 I HEREBY CERTIFY That I attended deceased from May 1, 1914, to May 2, 1914,
 that I last saw him alive on May 2, 1914

 and that death occurred on the date stated above, at 4¹⁵ a.m.
 The CAUSE OF DEATH* was as follows:
Calcium Tuberculosis
 (Duration) 8 yrs. 3 mos. 3 ds.
 Contributory (Secondary) Chronic Bronchitis

 (Signed) Dr. Schuman, M.D.
May 5, 1914 (Address) 330 N. Calvert St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

16 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

 Where was disease contracted,
 If not at place of death?

Former or usual residence

 19 PLACE OF BURIAL OR REMOVAL Sacred Heart Cem. DATE OF BURIAL May 5th, 1914

 20 UNDERTAKER Lilly & Zeller ADDRESS 403 S. Wolfe St.

If more blanks are needed, address State Registrar, U. S. Franklin St., Balto., Requesting V. S. No. 1.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

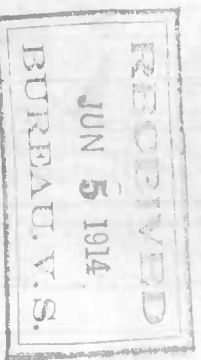
[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Cool mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Group"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc.. *Carcin-*

oma, *Sarcoma*, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness" etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and quality as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.



WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH 4690

County BaltimoreVillage or City Woodbrook (No. Haddon Av. St.; Ward)

2 FULL NAME

Friedericka PohlmanSTATE OF MARYLAND
CERTIFICATE OF DEATHRegistered No. 38

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE white 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Widow
(Write the word)6 DATE OF BIRTH January 1, 1825
(Month) (Day) (Year)7 AGE 89 yrs. 4 mos. 12 ds. If LESS than 1 day, hrs. OR min. ?8 OCCUPATION
(a) Trade, profession, or particular kind of work none
(b) General nature of industry, business, or establishment in which employed (or employer) none9 BIRTHPLACE (State or country) GermanyPARENTS 10 NAME OF FATHER Fred. Neimyr11 BIRTHPLACE OF FATHER (State or country) Germany12 MAIDEN NAME OF MOTHER Schmalhausen13 BIRTHPLACE OF MOTHER (State or country) Germany

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

Informant Mr. Wm. J. Pohlman(Address) Woodbrook Md15 Filed May 13, 1914 M. J. Porter
Deputy Clerk REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH May 12, 1914
(Month) (Day) (Year)17 I HEREBY CERTIFY, That I attended deceased from May 12, 1914 to May, 1914, that I last saw him alive on , 1914and that death occurred on the date stated above, at 8 P. m.

The CAUSE OF DEATH* was as follows:

myocarditis

Contributory (Duration) yrs. mos. ds.

Contributory (Secondary) Old age(Signed) John A. Cramer, M. D.May 12, 1914 (Address) 101 N. Carey

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, If not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Loudon Park Ctg May 15, 1914

20 UNDERTAKER ADDRESS

Stewart Morwen Co 217 Park Av.

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

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Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritonaeum*, etc. *Carcin-*

oma, *Sarcoma*, etc., of _____ (name organ; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 *ds.*; *Bronchopneumonia* (secondary), 10 *ds.* Never report mere symptoms or terminal conditions, such as "As-thenia," "Anæmia" (merely symptomatic); "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Træmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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RECEIVED

JUN 5 1914

BUREAU, V. S.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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1 PLACE OF DEATH County <u>Balto</u>			4691			175			STATE OF MARYLAND CERTIFICATE OF DEATH		
Village or City <u>Mt Vernon</u>			No. _____			St. _____			Registered No. <u>42</u>		
2 FULL NAME <u>Ernest Prener</u>			[If death occurred in a hospital or institution, give its NAME instead of street and number.]								
PERSONAL AND STATISTICAL PARTICULARS											
3 SEX <u>Male</u>		4 COLOR OR RACE <u>white</u>		5 SINGLE, MARRIED, WIDOWED, OR DIVORCED <u>single</u> (Write the word)							
6 DATE OF BIRTH <u>March 28</u> , 188 <u>4</u>		(Month) (Day) (Year)									
7 AGE <u>30</u> yrs. <u>1</u> mos. <u>12</u> ds.		If LESS than 1 day, ____ hrs. OR ____ min. ?									
8 OCCUPATION (a) Trade, profession, or particular kind of work. (b) General nature of industry, business, or establishment in which employed (or employer)		<u>Fireman</u> <u>Sas Co.</u>									
9 BIRTHPLACE (State or country)		<u>Germany</u>									
PARENTS	10 NAME OF FATHER		<u>Nicholas Prener</u>								
	11 BIRTHPLACE OF FATHER (State or country)		<u>Germany</u>								
	12 MAIDEN NAME OF MOTHER		<u>Catherine Cassard</u>								
13 BIRTHPLACE OF MOTHER (State or country)		<u>Germany</u>									
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>Catherine Prener</u> (Address) <u>15 E. West St.</u>											
15 Filed <u>May 10</u> , 191 <u>4</u>		F. H. Ruck REGISTRAR									
MEDICAL CERTIFICATE OF DEATH											
16 DATE OF DEATH <u>May 10</u> , 191 <u>4</u>		(Month) (Day) (Year)									
17 I HEREBY CERTIFY, That I attended deceased from _____, 191____, to _____, 191____, that I last saw him alive on _____, 191____, and that death occurred on the date stated above, at _____ m.											
The CAUSE OF DEATH* was as follows: <u>Cut in half and lower part of body mangled by B&O R.R. train at Heatport Balto. Co. Md. on May 10/14</u>											
(Duration) ____ yrs. ____ mos. ____ ds.											
Contributory (Secondary) _____											
(Signed) <u>Chas J. Hull, Coroner</u> <u>May 10</u> , 191 <u>4</u> (Address) <u>Mt Vernon, Balto. Co. Md.</u>											
*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.											
16 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)											
At place of death ____ yrs. ____ mos. ____ ds.		In the State ____ yrs. ____ mos. ____ ds.									
Where was disease contracted, If not at place of death? _____											
Former or usual residence _____											
19 PLACE OF BURIAL OR REMOVAL <u>Bedard Hill Cem.</u>						DATE OF BURIAL <u>May 12</u> , 191 <u>4</u>					
20 UNDERTAKER <u>E. Schloman & Son</u>						ADDRESS <u>1039</u>					
If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.											

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

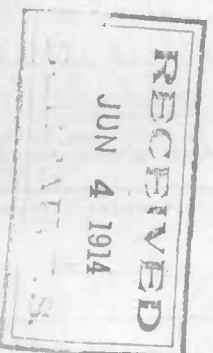
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Statement of cause of death.—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is inadequate); *Tuberculosis of lungs*, *meninges*, *peritonaeum*, etc. *Carcin-*

oma, *Sarcoma*, etc., of _____ (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.*; *Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Typhemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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¹ PLACE OF DEATH 4692
County Baltimore

Village or City For Howard No. _____

² FULL NAME Thomas L. Furnell

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No. 44

St.; _____ Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

PERSONAL AND STATISTICAL PARTICULARS

³ SEX Male ⁴ COLOR OR RACE White ⁵ SINGLE, MARRIED, WIDOWED, OR DIVORCED Midover
(Write the word)

⁶ DATE OF BIRTH Nov 27, 1864
(Month) (Day) (Year)

⁷ AGE 49 yrs. 5 mos. 13 ds. If LESS than 1 day, ____ hrs. OR ____ min. ?

⁸ OCCUPATION
(a) Trade, profession, or particular kind of work. Plaster
(b) General nature of industry, business, or establishment in which employed (or employer)

⁹ BIRTHPLACE (State or country) North Carolina

¹⁰ NAME OF FATHER Unknown

¹¹ BIRTHPLACE OF FATHER (State or country) Unknown

¹² MAIDEN NAME OF MOTHER Unknown

¹³ BIRTHPLACE OF MOTHER (State or country) Unknown

¹⁴ THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Frank Stuever

(Address) For Howard Md

¹⁵ Filed May 11th, 1914 G. C. McComick
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

¹⁶ DATE OF DEATH May 10, 1914
(Month) (Day) (Year)

¹⁷ I HEREBY CERTIFY, That I attended deceased from May 8, 1914, to May 10, 1914.

that I last saw him alive on May 10, 1914

and that death occurred on the date stated above, at 10:45 P. m.

The CAUSE OF DEATH* was as follows:

Myocardial Regurgitation

(Duration) 5 yrs. ____ mos. ____ ds.

Contributory Mecklenburg, Chronic
Secondary

(Duration) ____ yrs. ____ mos. ____ ds.

(Signed) Paul Stuever M. D.

May 10, 1914 (Address) For Howard Md

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

¹⁸ LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ____ yrs. ____ mos. ____ ds. In the State ____ yrs. ____ mos. ____ ds.

Where was disease contracted, If not at place of death?

Former or usual residence

¹⁹ PLACE OF BURIAL OR REMOVAL Bethairal U.S. DATE OF BURIAL May 12, 1914

²⁰ UNDERTAKER H. Sander & Sons ADDRESS 1710 8th St

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

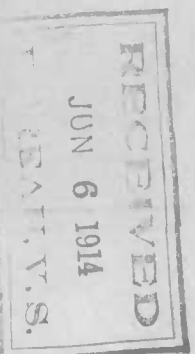
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1 PLACE OF DEATH

4693

County BaltimoreVillage or City St. Agnes Hospital (No. _____)

St. _____ Ward _____

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

Registration Dist. No. 4292 FULL NAME Baby Raichlyn

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White

5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word)

Single

6 DATE OF BIRTH

May 11, 1914
(Month) (Day) (Year)

7 AGE

If LESS than 1 day, _____ hrs.
_____ yrs. _____ mos. _____ ds. OR _____ min. ?8 1/2 born

8 OCCUPATION

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE

(State or country)

St. Agnes Hosp. Balto. Md.

PARENTS

10 NAME OF FATHER

Abraham Raichlyn

11 BIRTHPLACE OF FATHER (State or country)

Russia

12 MAIDEN NAME OF MOTHER

Polly Rodowick
Pearl Wooddaff

13 BIRTHPLACE OF MOTHER (State or country)

Russia

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mr. Abraham Raichlyn(Address) 1518 E. Baltimore

15

Filed May 12, 1914 St. Agnes Hospital

REGISTRAR

STATE OF MARYLAND
CERTIFICATE OF DEATH

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

Still born, 191____
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from

191____, to 191____,

that I last saw her alive on 191____

and that death occurred on the date stated above, at _____ m.

The CAUSE OF DEATH* was as follows:

Still born

(Duration) _____ yrs. _____ mos. _____ ds.

Contributory
Secondary

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) Henry H. Loos, M. D.May 11, 1914 (Address) St. Agnes Hospital

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

All place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds.

Where was disease contracted, If not at place of death?

Former or usual residence _____

19 PLACE OF BURIAL OR REMOVAL

Workman Circle Mt. Carmel

DATE OF BURIAL

May 13, 1914

20 UNDERTAKER

Jack Lewis

ADDRESS

1419 E. Baltimore

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

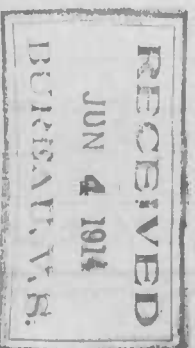
[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At Home*, and children, not gainfully employed, as *At school or At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None.*

Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc., Carcin-*

oma, Sarcoma, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) infection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH Balto 4694
 County Balto
 Village or City Canton (No. 3502 Fruit Ave)
 St.; Ward) Registration Dist. No. 41
 2 FULL NAME Hellen Reif

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

PERSONAL AND STATISTICAL PARTICULARS

3 SEX <u>Female</u>	4 COLOR OR RACE <u>White</u>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) <u>single</u>
6 DATE OF BIRTH <u>Jan 28</u> , 191 <u>3</u> (Month) (Day) (Year)		
7 AGE <u>X</u> yrs. <u>16</u> mos. <u>4</u> ds.		If LESS than 1 day, ____ hrs. OR ____ min. ?
8 OCCUPATION (a) Trade, profession, or particular kind of work <u>None</u> (b) General nature of industry, business, or establishment in which employed (or employer) <u>None</u>		
9 BIRTHPLACE (State or country) <u>Balto Co Ind</u>		
10 NAME OF FATHER <u>George Reif</u>		
11 BIRTHPLACE OF FATHER (State or country) <u>Balto City</u>		
12 MAIDEN NAME OF MOTHER <u>Mary Burger</u>		
13 BIRTHPLACE OF MOTHER (State or country) <u>Germany</u>		

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

Informant

(Address)

15

Filed

May 30, 1914 W.E. McCannanREGISTRAR W.D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH May 28, 1914
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from May 28, 1914, to May 28, 1914, that I last saw her alive on May 28, 1914, and that death occurred on the date stated above, at 10³⁰ p m.

The CAUSE OF DEATH* was as follows:
Convulsions
exhaustion

(Duration) X yrs. X mos. 1 ds.

Contributory (Secondary) Lobular Pneumonia

(Duration) X yrs. X mos. 7 ds.

(Signed) Jos. L. Truax, M.D.
May 29, 1914. (Address) 248 So. Third St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ____ yrs. ____ mos. ____ ds. In the State ____ yrs. ____ mos. ____ ds.

Where was disease contracted, If not at place of death? _____

Former or usual residence _____

19 PLACE OF BURIAL OR REMOVAL <u>Holy Redeemer Ch.</u>	DATE OF BURIAL <u>May 30</u> , 191 <u>4</u>
20 UNDERTAKER <u>Filly and Filler</u>	ADDRESS <u>403 S. Maple</u>

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

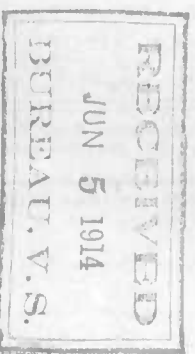
[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritonaeum*, etc.. *Carcin-*

oma, *Sarcoma*, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.*; *Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congential," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state YEARS OF INJURY and quality as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such. If impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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1 PLACE OF DEATH 4695

County BaltimoreSTATE OF MARYLAND
CERTIFICATE OF DEATHRegistration Dist. No. 30Village or City Catonsville (No. Cooks Lane St.; Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME Nathan Richardson

PERSONAL AND STATISTICAL PARTICULARS

3 SEX male 4 COLOR OR RACE Cald 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED widowed
(Write the word)

6 DATE OF BIRTH Unk Unk
(Month) (Day) (Year)

7 AGE 79 yrs. — mos. — ds. If LESS than 1 day, — hrs. OR — min. ?

8 OCCUPATION (a) Trade, profession, or particular kind of work Laboer
(b) General nature of Industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE (State or country) Balto Co

PARENTS
10 NAME OF FATHER Nathan Richardson
11 BIRTHPLACE OF FATHER (State or country) Unk
12 MAIDEN NAME OF MOTHER Unk
13 BIRTHPLACE OF MOTHER (State or country) Unk

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Amos Richardson
(Address) Clark St. Calverton Md

15 Filed May 15, 1914 Marshall B Wirt
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH May 14 or 15, 1914
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from _____, 191____, to _____, 191____,

that I last saw h _____ alive on _____, 191____

and that death occurred on the date stated above, at _____ m.

The CAUSE OF DEATH* was as follows:

went to bed as well as usual about 9 Pm did not come to breakfast went to his room to see why & found him dead. (Duration) _____ yrs. _____ mos. _____ ds.

Contributory
Secondary

(Signed) Wm S. Hoffman (Duration) _____ yrs. _____ mos. _____ ds.
May 15, 1914 (Address) Catonsville Md

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds.

Where was disease contracted, If not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL Western Star DATE OF BURIAL May 16, 1914

20 UNDERTAKER Ed W Pye ADDRESS Catonsville

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

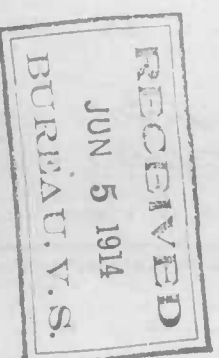
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oma, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 d.; *Bronchopneumonia* (secondary), 10 d. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Scarle," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Thanthon," "Marasmus," "Old Age," "Shock," "Træmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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1 PLACE OF DEATH

4696

County

Village or City

(No.

Registration Dist. No.

St.; Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 SINGLE, MARRIED, WIDDED, OR DIVORCED (Write the word)

6 DATE OF BIRTH

7 AGE

It LESS than 1 day, hrs. yrs. mos. ds. OR min. ?

8 OCCUPATION

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE

(State or country)

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (State or country)

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15

Filed

REGISTRAR

STATE OF MARYLAND
CERTIFICATE OF DEATH

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

17

I HEREBY CERTIFY, That I attended deceased from

that I last saw him alive on

and that death occurred on the date stated above, at

The CAUSE OF DEATH* was as follows:

Contributory
Secondary

(Signed)

1914 (Address)

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and, (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

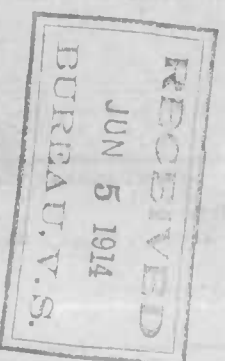
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1 PLACE OF DEATH County <u>Balto.</u>		4697		79		STATE OF MARYLAND CERTIFICATE OF DEATH	
Village or City <u>Poplar Heights</u>		(No. <u> </u>)		St.; Ward)		Registration Dist. No. <u>444</u>	
2 FULL NAME <u>Mary Russell</u>		[If death occurred in a hospital or institution, give its NAME instead of street and number.]					
PERSONAL AND STATISTICAL PARTICULARS							
3 SEX <u>Female</u>	4 COLOR OR RACE <u>Col.</u>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) <u>married</u>					
6 DATE OF BIRTH <u>May 13</u> , 18 <u>75</u> (Month) (Day) (Year)		7 AGE <u>39</u> yrs. — mos. — ds. If LESS than 1 day, hrs. OR min. ?					
8 OCCUPATION (a) Trade, profession, or particular kind of work <u>Housewife</u> (b) General nature of Industry, business, or establishment in which employed (or employer) <u>Housewife</u>							
9 BIRTHPLACE (State or country) <u>Virginia</u>							
PARENTS	10 NAME OF FATHER <u>Pleasant Davis</u>						
	11 BIRTHPLACE OF FATHER (State or country) <u>Virginia</u>						
	12 MAIDEN NAME OF MOTHER <u>unknown</u>						
	13 BIRTHPLACE OF MOTHER (State or country) <u>Va.</u>						
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Interman) <u>Edward Russell</u> (Address) <u>Poplar Heights</u>							
15 Filed <u>May 12</u> , 191 <u>4</u> <u>G. L. McCormick</u> REGISTRAR							
MEDICAL CERTIFICATE OF DEATH							
16 DATE OF DEATH <u>May 12th</u> , 191 <u>4</u> (Month) (Day) (Year)							
17 I HEREBY CERTIFY, That I attended deceased from <u>May 12</u> , 191 <u>4</u> , to <u>May 12</u> , 191 <u>4</u> , that I last saw her alive on <u>May 8th</u> , 191 <u>4</u> , and that death occurred on the date stated above, at <u>11.30 P.</u> m.							
The CAUSE OF DEATH* was as follows: <u>Valvular disease of heart</u> (Duration) <u>4</u> yrs. — mos. — ds. Contributory <u>Ascites</u> , Secondary (Duration) <u>4</u> yrs. — mos. — ds. (Signed) <u>G. L. McCormick</u> , M. D. <u>May 12</u> , 191 <u>4</u> (Address) <u>Spencer Point</u>							
*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.							
18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS) At place of death yrs. mos. ds. In the State yrs. mos. ds. Where was disease contracted, If not at place of death? Former or usual residence.							
19 PLACE OF BURIAL OR REMOVAL <u>Ashbury Cemetery</u>				DATE OF BURIAL <u>May 14</u> , 191 <u>4</u>			
20 UNDERTAKER <u>Felix B. Pye</u>				ADDRESS <u>Balto.</u>			

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

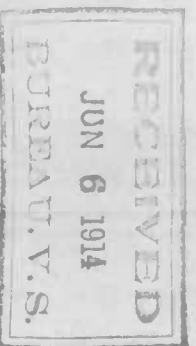
[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritonaeum*, etc., *Carcin-*

oma, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL *septicæmia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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1 PLACE OF DEATH

4698

120

STATE OF MARYLAND
CERTIFICATE OF DEATHCounty BaltoRegistration Dist. No. 44Village or City Beargis (No. _____, St.; _____ Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME William H Russell

PERSONAL AND STATISTICAL PARTICULARS

3 SEX M 4 COLOR OR RACE Col 5 SINGLE, MARRIED, WIDDED, OR DIVORCED Widowed
(Write the word)

6 DATE OF BIRTH _____, 1830
(Month) (Day) (Year)

7 AGE 84 yrs. — mos. — ds. It LESS than 1 day. — hrs. OR — min. ?

8 OCCUPATION
(a) Trade, profession, or particular kind of work Plasterer
(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE (State or country) md

PARENTS
10 NAME OF FATHER Unknown
11 BIRTHPLACE OF FATHER (State or country) md
12 MAIDEN NAME OF MOTHER Unknown
13 BIRTHPLACE OF MOTHER (State or country) md

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Ernie Brown(Address) Smallsport md

15 Filed May 4, 1914 J W Harrison M D
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH May 13, 1914
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from April 1, 1914, to May 13, 1914.

that I last saw him alive on April 16, 1914.

and that death occurred on the date stated above, at 2 A m.

The CAUSE OF DEATH* was as follows:

Debilitation of Heart(Duration) 6 yrs. — mos. — ds.Contributory Chronic Bright's Disease
Secondary of the heart(Duration) 2 yrs. — mos. — ds.

(Signed) John C. Harrison M D, M. D.
May 14, 1914 (Address) Smallsport md

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds.

Where was disease contracted, if not at place of death?

Former or usual residence _____

19 PLACE OF BURIAL OR REMOVAL Sharp St Cecil DATE OF BURIAL May 16, 1914

20 UNDERTAKER Chas Falty ADDRESS Russell

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

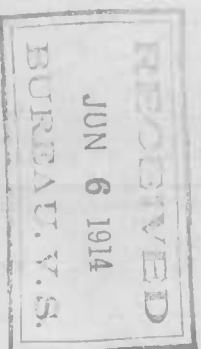
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Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meningis, peritonaeum*, etc., *Carcin-*

oma, Sarcoma, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Tremula," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septiœmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on Statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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1 PLACE OF DEATH

4699

County

Balto Md.

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No.

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

Village or City

St. Agnes' Hospital.

St.

Ward

2 FULL NAME

Charles Schaeffer

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word)

Married

6 DATE OF BIRTH

Do not know, 1853

7 AGE

59 yrs.

1 mos.

1 ds.

If LESS than 1 day, hrs. OR min. ?

8 OCCUPATION

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

Carpenter

9 BIRTHPLACE

(State or country)

Russia

PARENTS

10 NAME OF FATHER

Mike Schaeffer

11 BIRTHPLACE OF FATHER (State or country)

Do not know

12 MAIDEN NAME OF MOTHER

Do not know

13 BIRTHPLACE OF MOTHER (State or country)

Do not know

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Mrs. Joseph Nicholas

(Address)

1619 Aliceanna St.

15

Filed

May 18, 1914 Goldshiraf

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

May

18

1914

(Month)

(Day)

(Year)

17

I HEREBY CERTIFY, That I attended deceased from

May 3, 1914

to

May 18, 1914

that I last saw him alive on

May 18, 1914

and that death occurred on the date stated above, at.....m.

The CAUSE OF DEATH* was as follows:

Carcinoma of gall bladder
metastases to liver, diaphragm & lung
gall stones.

(Duration)

?

yrs.

mos.

ds.

Contributory
Secondary

Toxaemia from obstruction of common duct

(Duration)

?

yrs.

mos.

ds.

(Signed)

Henry H. Ross

, M. D.

May 18, 1914

(Address) St. Agnes' Hosp.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

16 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place

of death

yrs.

mos.

15 ds.

In the

State

59 yrs.

mos.

ds.

Where was disease contracted,

If not at place of death?

Former or

usual residence

1619 Aliceanna St.

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

St. Stanislaus Cem.

May 17, 1914

20 UNDERTAKER

ADDRESS

M. F. Sadowski.

705 S. Ann. St.

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

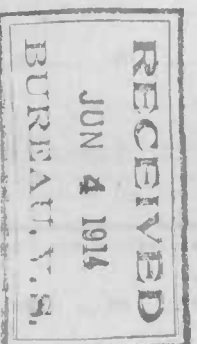
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1 PLACE OF DEATH <u>4700</u>		STATE OF MARYLAND CERTIFICATE OF DEATH	
County <u>Baltimore</u>			
Village or City <u>Canton</u> (No. <u>1007 S East Ave</u> St. _____ Ward _____)		Registration Dist. No. <u>41</u>	
2 FULL NAME <u>Schaller</u>			
PERSONAL AND STATISTICAL PARTICULARS			
3 SEX <u>Female</u>	4 COLOR OR RACE <u>White</u>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) <u>Single</u>	
6 DATE OF BIRTH <u>May 24, 1914</u> (Month) (Day) (Year)			
7 AGE _____ yrs. _____ mos. _____ ds. OR _____ min. ?		If LESS than 1 day, _____ hrs.	
8 OCCUPATION (a) Trade, profession, or particular kind of work <u>none</u> (b) General nature of industry, business, or establishment in which employed (or employer) _____			
9 BIRTHPLACE (State or country) <u>Maryland</u>			
PARENTS	10 NAME OF FATHER <u>John S Schaller</u>		
	11 BIRTHPLACE OF FATHER (State or country) <u>Maryland</u>		
	12 MAIDEN NAME OF MOTHER <u>Minnie Taylor</u>		
	13 BIRTHPLACE OF MOTHER (State or country) <u>Maryland</u>		
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>John Schaller</u> (Address) <u>1007 S East Ave</u>			
15 Filed <u>May 25, 1914</u> <u>W. E. W. Clausen</u> REGISTRY <u>Stephen J. Fialkowski</u>			
MEDICAL CERTIFICATE OF DEATH			
16 DATE OF DEATH <u>May 24, 1914</u> (Month) (Day) (Year)			
17 I HEREBY CERTIFY, That I attended deceased from _____, 191____, to _____, 191____.			
that I last saw him _____ alive on _____, 191____.			
and that death occurred on the date stated above, at _____ m.			
The CAUSE OF DEATH* was as follows: <u>4 month Foetus</u> (Duration) _____ yrs. _____ mos. _____ ds.			
Contributory _____ Secondary _____ (Signed) <u>H. B. Titlow</u> , M. D. <u>May 24, 1914</u> (Address) <u>303 S O'Donnell</u>			
*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.			
18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS) At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds.			
Where was disease contracted, If not at place of death? _____			
Former or usual residence _____			
19 PLACE OF BURIAL OR REMOVAL <u>St. Stanislaus Ben</u>		DATE OF BURIAL <u>May 25, 1914</u>	
20 UNDERTAKER <u>Stephen J. Fialkowski</u>		ADDRESS <u>1027 S Glenwood</u>	

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

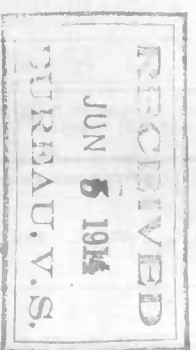
[Approved by U. S. Census and American Public Health Association.]

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Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcin-*

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1 PLACE OF DEATH 4701
 County Baltimore
 Village or City English Consul (No. _____, St. _____ Ward _____)
 2 FULL NAME Annie Schroll (6 mos)
 STATE OF MARYLAND
 CERTIFICATE OF DEATH
 Registration Dist. No. 1425
 [If death occurred in a hospital or institution, give its NAME instead of street and number.]

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Infant
 (Write the word)
 6 DATE OF BIRTH May 25, 1914
 (Month) (Day) (Year)
 7 AGE no yrs. no mos. no ds. If LESS than 1 day, 6 hrs. OR 30 min. ?

8 OCCUPATION
 (a) Trade, profession, or particular kind of work
 (b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE (State or country) md

PARENTS
 10 NAME OF FATHER Henry Schroll
 11 BIRTHPLACE OF FATHER (State or country) md
 12 MAIDEN NAME OF MOTHER Rosa Locher
 13 BIRTHPLACE OF MOTHER (State or country) md

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Rosa Schroll
 (Address) English Consul

15 Filed May 26 1914 F - J. R. R. R.
 REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH May 26, 1914
 (Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from May 25, 1914, to May 26, 1914.

that I last saw her alive on May 25, 1914.

and that death occurred on the date stated above, at 12:00 a.m.

The CAUSE OF DEATH* was as follows:

6 months birth

(Duration) _____ yrs. _____ mos. _____ ds.

Contributory
 Secondary

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) R. V. Schroll, M. D.
May 26, 1914 (Address) md

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds.

Where was disease contracted, if not at place of death?

Former or usual residence _____

19 PLACE OF BURIAL OR REMOVAL Hawk cemetery DATE OF BURIAL May 27, 1914

20 UNDERTAKER A. Jones ADDRESS 207 S. Stricker

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry; and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Maanager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not faintfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberclests of lungs, meningies, peritonaeum*, etc., *Carcin-*

oma, Sarcoma, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Typhemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PREPERAL septiclaemia," "PREPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For violent DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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RECEIVED

JUN 4 1914

DEPARTMENT OF V. S.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH 4702
County Balto

Village or City Highlandtown No. 3207 E Lombard

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No. 41

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME Frederick Schumm

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Married
(Write the word)

6 DATE OF BIRTH Sept 22, 1859
(Month) (Day) (Year)

7 AGE 54 yrs. 7 mos. 26 ds. If LESS than 1 day, hrs. OR mo. ?

8 OCCUPATION
(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer)

Cooper

9 BIRTHPLACE
(State or country)

Germany

10 NAME OF FATHER John Schumm

11 BIRTHPLACE OF FATHER
(State or country)

Germany

12 MAIDEN NAME OF MOTHER

Mary-K. Sauer

13 BIRTHPLACE OF MOTHER
(State or country)

Germany

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Mrs. Mary M. Schumm

(Address)

3207 E Lombard St

15

Filed

May 19, 1914

Registered

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH May 18, 1914
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from Jan 1, 1914, to May 18, 1914, that I last saw him alive on May 15, 1914

and that death occurred on the date stated above, at 8:00 a.m.
The CAUSE OF DEATH* was as follows:

Pulmonary Interstitial

sen (Duration) yrs. mos. ds.

Contributory
(Secondary)

Fisher is Arter

sen (Duration) yrs. mos. ds.

(Signed) Walter H. White, M. D.

May 19, 1914 (Address) 1101 Bway

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, OR HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, If not at place of death?

Former or usual residence.

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Secret Heart Cemetery May 21, 1914

20 UNDERTAKER

ADDRESS

Henry Jacobson 1301 E Eager St

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

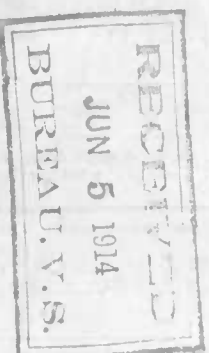
[Approved by U. S. Census and American Public Health Association.]

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Statement of cause of death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc. *Carcin-*

oma, *Sarcoma*, etc., of _____ (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.*; *Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congestant," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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1 PLACE OF DEATH 4703

County Balto CoVillage or City Roland Park (No. 409 Forest Road St.; Ward)STATE OF MARYLAND
CERTIFICATE OF DEATHRegistration Dist. No. 38

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME Mary B Schwartz

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Fi 4 COLOR OR RACE br 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) Single

6 DATE OF BIRTH Aug 12, 1885
(Month) (Day) (Year)

7 AGE 69 yrs 8 mos 21 ds. If LESS than 1 day, hrs. OR min. ?

8 OCCUPATION
(a) Trade, profession, or particular kind of work House work.
(b) General nature of industry, business, or establishment in which employed (or employer) at Home.

9 BIRTHPLACE (State or country) Balto Md.

10 NAME OF FATHER Julius Schwartz

11 BIRTHPLACE OF FATHER (State or country) Germany.

12 MAIDEN NAME OF MOTHER Catherine Hilbrand

13 BIRTHPLACE OF MOTHER (State or country) Germany.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) F. A. Church

(Address) 409 Forest Road

15 Filed May 3, 1914 M. G. Porter
Deputy REGISTRAR

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH March 16, 1914
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from March 16, 1914, to May 3, 1914, that I last saw her alive on May 3, 1914

and that death occurred on the date stated above, at 20 m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage
Right Hemiplegia
(Duration) 1 yrs. 18 mos. 18 ds.

Contributory Secondary

(Duration) yrs. mos. ds.
(Signed) M. G. Porter M. D.
May 3, 1914 (Address) Roland Park Md

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Green Mount Cemetery May 5, 1914

20 UNDERTAKER ADDRESS

Wm. Montross Green Mount Cemetery

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

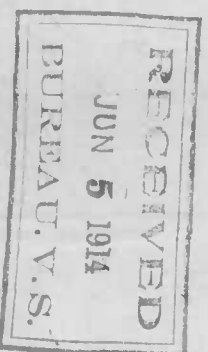
[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Group"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tubercle* of *lungs, meninges, peritoneum*, etc., *Carcin-*

oma, Sarcoma, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Contributory," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Traemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on nomenclature of death approved by Committee on Nomenclature of the American Medical Association.)

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1 PLACE OF DEATH

4704

County

Baltimore

Village or City

Rosedale No.

2 FULL NAME

Ernest Serati

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No.

44

St: Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 SINGLE,
MARRIED,
WIDOWED,
OR DIVORCED
(Write the word)

Widow

6 DATE OF BIRTH

March 10, 1842
(Month) (Day) (Year)

7 AGE

72 yrs. 2 mos. 2 ds.

If LESS than
1 day, hrs.
OR min.?

8 OCCUPATION

(a) Trade, profession, or particular kind of work

Farmer

(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE
(State or country)

Germany

10 NAME OF FATHER

John Serati

11 BIRTHPLACE OF FATHER
(State or country)

Germany

12 MAIDEN NAME OF MOTHER

Kubusow

13 BIRTHPLACE OF MOTHER
(State or country)

Germany

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

State Registrar

(Address)

Rosedale Md

15

Filed

May 13, 1914

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

May 12, 1914
(Month) (Day) (Year)

17

I HEREBY CERTIFY that I attended deceased from

Apr 1, 1913 to May 12, 1914

that I last saw him alive on May 11, 1914

and that death occurred on the date stated above, at 10 a. m.

The CAUSE OF DEATH* was as follows:

Cerebral irritation
and chronic nephritis

(Duration) 1 yrs. 8 mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

C. W. Lantz, M. D.

May 12, 1914 (Address) Rosedale

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted,

If not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Howard Cemetery May 13, 1914

20 UNDERTAKER

ADDRESS

C. W. Lantz Rosedale Md

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

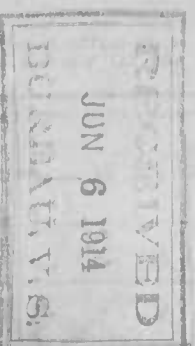
[Approved by U. S. Census and American Public Health Association.]

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1 PLACE OF DEATH 4705
County Baltimore

Village or City Northview (No. 1000)

2 FULL NAME Sarah J. Shannon

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No. 42

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE Colored 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Married
(Write the word)

6 DATE OF BIRTH Sept —, 1888
(Month) (Day) (Year)

7 AGE 25 yrs. 8 mos. — ds. If LESS than 1 day, — hrs. OR — min. ?

8 OCCUPATION
(a) Trade, profession, or particular kind of work Housework.
(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE (State or country) md.

PARENTS
10 NAME OF FATHER Dorfin Heigels
11 BIRTHPLACE OF FATHER (State or country) md.
12 MAIDEN NAME OF MOTHER Sarah Heigels
13 BIRTHPLACE OF MOTHER (State or country) md.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Adolf Shannon
(Address) Northview

15 Filed May 26, 1914 J. H. Kuhl
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH May, 26, 1914
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from May 15, 1914, to May 26, 1914, that I last saw her alive on May 25, 1914.

and that death occurred on the date stated above, at 4 a. m.
The CAUSE OF DEATH* was as follows:

Tuberculosis
General
(Duration) — yrs. 6 mos. — ds.

Contributory Exhaustion
Secondary

(Signed) Russell, M. D.
May 26, 1914 (Address) Northview

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)
At place of death — yrs. — mos. — ds. In the State — yrs. — mos. — ds.

Where was disease contracted, If not at place of death?
Former or usual residence

19 PLACE OF BURIAL OR REMOVAL Good Hope DATE OF BURIAL May 27, 1914

20 UNDERTAKER Cambria & Son ADDRESS 409 Little Rock

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not faithfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcin-*

oma, Sarcoma, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Træmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal *septicaemia*," "Puerperal *peritonitis*," etc. State cause for which surgical operation was undertaken. For violent deaths state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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RECEIVED
JUN 4 1914
BUREAU, V. S.

STATE OF MARYLAND
CERTIFICATE OF DEATH1 PLACE OF DEATH
County BaltoRegistration Dist. No. 44Village or City Turner Station (No. _____, St.; Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME Alice Shields

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE Colored 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED married
(Write the word)6 DATE OF BIRTH Unknown
(Month) (Day) (Year)7 AGE 32 yrs. — mos. — ds. If LESS than 1 day, — hrs. OR — min. ?8 OCCUPATION
(a) Trade, profession, or particular kind of work Housework
(b) General nature of industry, business, or establishment in which employed (or employer)9 BIRTHPLACE (State or country) Maryland10 NAME OF FATHER Thomas Gundy
11 BIRTHPLACE OF FATHER (State or country) Va12 MAIDEN NAME OF MOTHER Henrietta Fox13 BIRTHPLACE OF MOTHER (State or country) Maryland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Thomas Gundy
(Address) Turner Station15 Filed May 12, 1914 G. H. McCormick
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH May 10, 1914
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from _____, 191____, to _____, 191____,

that I last saw him alive on _____, 191____

and that death occurred on the date stated above, at _____ m.

The CAUSE OF DEATH* was as follows:

Homicide
Shot through the
Heart (Duration) _____ yrs. _____ mos. _____ ds.Contributory
Secondary(Signed) J. H. Warner, M. D.
May 10, 1914 (Address) Coroner

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds.

Where was disease contracted, if not at place of death?

Former or usual residence _____

19 PLACE OF BURIAL OR REMOVAL Ever Green Cem DATE OF BURIAL May 13, 191420 UNDERTAKER Sam'l H. Chase ADDRESS 1400 Mosher

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

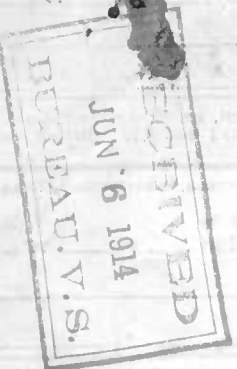
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Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcin-*

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1 PLACE OF DEATH

4707

County

Baltimore

Berry Ave

Village or City

Fullerton

(No.

Md

Registration Dist. No.

43

St.; Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME

Ruby Shipley

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White

5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word)

Single

6 DATE OF BIRTH

8

15

1913

(Month)

(Day)

(Year)

7 AGE

— yrs.

7 mos.

18 ds.

If LESS than 1 day, hrs. OR min. ?

8 OCCUPATION

(a) Trade, profession, or particular kind of work

None

(b) General nature of industry, business, or establishment in which employed (or employer)

None

9 BIRTHPLACE

(State or country)

Maryland

PARENTS

10 NAME OF FATHER

Wm H Shipley

11 BIRTHPLACE OF FATHER (State or country)

Maryland

12 MAIDEN NAME OF MOTHER

Vida E Shipley

13 BIRTHPLACE OF MOTHER (State or country)

Maryland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

W H Shipley

(Address)

Fullerton Md

15

Filed

May 4, 1914 W L Clayton

REGISTRAR

STATE OF MARYLAND
CERTIFICATE OF DEATH

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

5

3

1914

(Month)

(Day)

(Year)

17 I HEREBY CERTIFY, That I attended deceased from

April 22, 1914, to May 3, 1914,

that I last saw her alive on May 21, 1914,

and that death occurred on the date stated above, at 8 a. m.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

(Duration)

yrs.

mos.

ds.

Contributory
Secondary

Meningitis

(Duration)

yrs.

mos.

ds.

(Signed)

W L Clayton

, M. D.

May 4, 1914 (Address) Overbe

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place

of death

In the

State

yrs. mos. ds.

Where was disease contracted,

If not at place of death?

Former or

usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Miss Cemetery

May 4th, 1914

20 UNDERTAKER

ADDRESS

Frederick Gosselin Fullerton Md

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

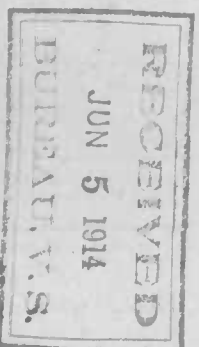
[Approved by U. S. Census and American Public Health Association.]

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Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meningis, peritoneum*, etc., *Carcin-*

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1 PLACE OF DEATH

4708

County

Baltimore

 STATE OF MARYLAND
 CERTIFICATE OF DEATH

Registration Dist. No. 33

Village or City

Reston

(No.

St.

Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME

Nathan Simon

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

M

4 COLOR OR RACE

W

5 SINGLE,

MARRIED,
WIDOWED,
OR DIVORCED
(Write the word)

Single

6 DATE OF BIRTH

(Month)

(Day)

(Year)

7 AGE

22

yrs.

mos.

ds.

 If LESS than
 1 day, hrs.
 OR min. ?

8 OCCUPATION

(a) Trade, profession, or particular kind of work

Clerk

(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE (State or country)

Russia

10 NAME OF FATHER

Mr. Simon

11 BIRTHPLACE OF FATHER (State or country)

Russia

12 MAIDEN NAME OF MOTHER

Unknown

13 BIRTHPLACE OF MOTHER (State or country)

Russia

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Dr. J. Cohen

(Address)

Gen. Consup. House

15

Filed

May 5, 1914 J. M. Black

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

 May 5th, 1914
 (Month) (Day) (Year)

17

I HEREBY CERTIFY, That I attended deceased from

November, 1913, to May 5, 1914.

that I last saw him alive on May 5th, 1914.

and that death occurred on the date stated above, at 9:15 a.m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(Duration) 2 yrs. mos. ds.

Contributory (Secondary)

Tuberculosis laryngitis

(Duration) 2 yrs. 7 mos. ds.

(Signed)

J. A. Cohen

, M. D.

191 (Address) Gen. Consup. House

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18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death 6 yrs. 6 mos. ds. In the State 12 yrs. mos. ds.

Where was disease contracted, Baltimore

Former or usual residence 709 S. Charles

19 PLACE OF BURIAL OR REMOVAL

Baltimore 709 S. Charles

DATE OF BURIAL

, 191

20 UNDERTAKER

Mr. Levinson

ADDRESS

1210 E. Baltimore

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

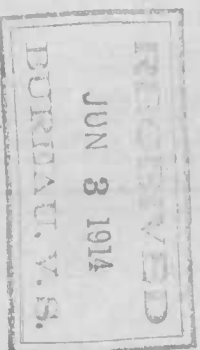
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1 PLACE OF DEATH

County Balto.

4709

STATE OF MARYLAND
CERTIFICATE OF DEATHRegistered No. 58Village or City Gorans (No. Hutchins Ave St.; _____ Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME

Charles Smith

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

Col5 SINGLE,
MARRIED,
WIDOWED,
OR DIVORCED
(Write the word)Widower

6 DATE OF BIRTH

Not Known
(Month) (Day) (Year)

7 AGE

65 yrs. — mos. — ds. OR 1 day, — hrs. — min. ?

8 OCCUPATION

(a) Trade, profession, or particular kind of work

Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

Laborer9 BIRTHPLACE
(State or country)Va

10 NAME OF FATHER

Not Known11 BIRTHPLACE OF FATHER
(State or country)Not Known

12 MAIDEN NAME OF MOTHER

Not Known13 BIRTHPLACE OF MOTHER
(State or country)Not Known

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Sam Ayers

(Address)

608 Raven Ave.

15

Filed

5/21, 1914 Charles Smith

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

May 20, 1914
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from

May 18, 1914, to May 20, 1914,
that I last saw him alive on May 20, 1914and that death occurred on the date stated above, at 11:50 P. m.

The CAUSE OF DEATH* was as follows:

Myocarditis and
Endocarditis

(Duration) — yrs. — mos. — ds.

Contributory
(Secondary)Arteriosclerosis(Duration) 5 yrs. — mos. — ds.(Signed) J. Royalty M. D.May 21, 1914 (Address) Wismar Md.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death — yrs. — mos. — ds. In the State — yrs. — mos. — ds.

Where was disease contracted,
If not at place of death?Former or
usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

W. Hubert5/22/14

20 UNDERTAKER

ADDRESS

Samuel T. Hensley 578 W. Biddle

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc. *Carcin-*

oma, *Sarcoma*, etc., of (name origin: "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congestial," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Træmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent DEATHS state MEANS OF INJURY and quality as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by runaway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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RECEIVED

JUN 5 1914

BUREAU, U. S.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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1 PLACE OF DEATH

4710

County BaltimoreVillage or City Roslyn (No.) St.; Ward)

2 FULL NAME

John C. Smith

(64) STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No. 31

[If death occurred in
a hospital or institution,
give its NAME instead
of street and number.]

PERSONAL AND STATISTICAL PARTICULARS

3 SEX male 4 COLOR OR RACE white 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Married
(Write the word)

6 DATE OF BIRTH March 27, 1837
(Month) (Day) (Year)

7 AGE 77 yrs. 1 mos. 22 ds. If LESS than 1 day, hrs. OR min. ?

8 OCCUPATION
(a) Trade, profession, or particular kind of work Farm
(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE (State or country) Germany

PARENTS
10 NAME OF FATHER Dont Know
11 BIRTHPLACE OF FATHER (State or country) Dont Know
12 MAIDEN NAME OF MOTHER Dont Know
13 BIRTHPLACE OF MOTHER (State or country) Dont Know

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) J. Harmon Kline(Address) Roslyn, Md.

15 Filed May 19, 1914 H. J. Shepler
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH May 19, 1914
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from Apr 27, 1914 to May 19, 1914

that I last saw him alive on May 18, 1914

and that death occurred on the date stated above, at 10:30 a.m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

Contributory (Duration) yrs. mos. 22 ds.
Secondary Arterio Sclerosis

(Signed) H. J. Shepler, M. D.
, 191 (Address) Sekonsky, Md.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted,
If not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL DATE OF BURIAL
Int. Ohio County May 21, 1914

20 UNDERTAKER ADDRESS
A. S. Marshall Baltimore, Md.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

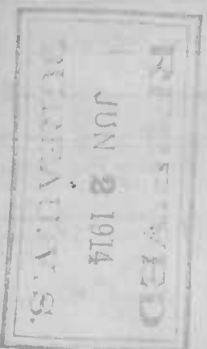
[Approved by U. S. Census and American Public Health Association.]

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Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcin-*

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1 PLACE OF DEATH

4711

County Balto.

(28)

STATE OF MARYLAND CERTIFICATE OF DEATH

Registration Dist. No. 41Village or City Canton (No. 3410 Elliott St.; Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME

Victoria Smith

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 SINGLE, MARRIED, Married, WIDOWED, OR DIVORCED (Write the word)

6 DATE OF BIRTH Aug 15, 1885 (Month) (Day) (Year)

7 AGE 28 yrs. 8 mos. 26 ds. If LESS than 1 day, hrs. OR min. ?

8 OCCUPATION (a) Trade, profession, or particular kind of work Housewife (b) General nature of industry, business, or establishment in which employed (or employer) at home

9 BIRTHPLACE (State or country) Balto. Co. Md.

10 NAME OF FATHER Martin Mandick

11 BIRTHPLACE OF FATHER (State or country) Austria

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (State or country) Germany

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Martin Smith(Address) 3410 Elliott St.

15 Filed May 11, 1914 W. E. McCluskey REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH May 9, 1914 (Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from March 4, 1914, to May 9, 1914.

that I last saw him alive on May 8, 1914.

and that death occurred on the date stated above, at 5:50 a. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis(Duration) 2 yrs. 4 mos. 4 ds.Contributory
Secondary(Duration) 7 yrs. 7 mos. 7 ds.(Signed) D. W. Jones, M. D.

May 18, 1914 (Address) 3146 Odum Rd.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, If not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Oak Lawn Cemetery May 12, 1914

20 UNDERTAKER ADDRESS

Lilly & Zeiler 403 S. Wolfe St.

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

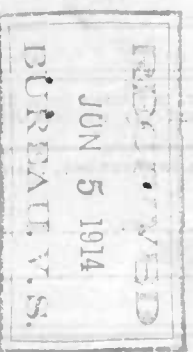
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1 PLACE OF DEATH

4712

County

Baltimore

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No.

41

Village or City

Highlandtown

(No.)

302 S. Highland Ave.

St.

Ward)

[If death occurred in
a hospital or institution,
give its NAME instead
of street and number.]

2 FULL NAME

Annie S. Ohu

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White

5 STATUS,

MARRIED,

WIDOWED,

OR DIVORCED

(Write the word)

widowed

6 DATE OF BIRTH

Nov

11

1831

(Month)

(Day)

(Year)

7 AGE

82

yrs.

6

mos.

11

ds.

If LESS than

1 day, hrs.

OR min. ?

8 OCCUPATION

(a) Trade, profession, or particular kind of work

at Home

(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE

(State or country)

Germany

PARENTS

10 NAME OF FATHER

Don't know

11 BIRTHPLACE OF FATHER

(State or country)

Germany

12 MAIDEN NAME OF MOTHER

Don't know

13 BIRTHPLACE OF MOTHER

(State or country)

Germany

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Philip Volk

(Address)

302 S. Highland Ave

15

Filed

June 1st, 1914

W. E. McLaughlin

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

5/29/14

(Month)

(Day)

1914 (Year)

17

I HEREBY CERTIFY, That I attended deceased from

5/29/14, 1914, to

5/29/14, 1914,

to

5/29/14, 1914,

to

5/29/14, 1914,

to

5/29/14, 1914,

that I last saw her

alive on

5/29/14, 1914,

to

5/29/14, 1914,

to

5/29/14, 1914,

5/29/14, 1914,

and that death occurred on the date stated above, at

8

P

m.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

(Duration)

7

yrs.

mos.

ds.

Contributory

Secondary

Pulmonary Emphysema

(Duration)

1

yrs.

mos.

3

(Signed)

J. H. Korman

M. D.

5/29/14, 1914 (Address)

2919 C. Balto

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18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place

of death

yrs.

mos.

ds.

In the

State

yrs.

mos.

ds.

Where was disease contracted,

If not at place of death?

Former or

usual residence.

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Jerusalem Cem

June 2, 1914

20 UNDERTAKER

ADDRESS

J. Herwig & Co

2008 Orleans St

If more blanks are needed, address State Registrar 6 E. Franklin St., Balto., Requesting V. S. No. 1.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

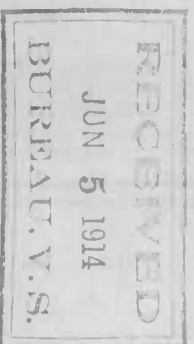
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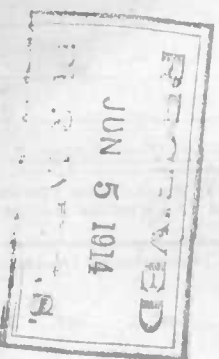
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oma, *Sarcoma*, etc., of _____ (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.*; *Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "As-thenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congential," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state MEANS OF INJURY and quality as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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1 PLACE OF DEATH

4714

County

Baltimore

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registered No.

30

Village or City

Catonsville

(No.

Spring Grove State Hospital

St.

Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME

Ella Spielman

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White

5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word)

Single

6 DATE OF BIRTH

November 17, 1874

(Month)

(Day)

(Year)

7 AGE

39 yrs. 6 mos. 9 ds.

If LESS than 1 day, hrs. OR, mcs. ?

8 OCCUPATION

(a) Trade, profession, or particular kind of work

None

(b) General nature of industry, business, or establishment in which employed (or employer)

None

9 BIRTHPLACE

(State or country)

Maryland

10 NAME OF FATHER

Otto Spielman

PARENTS

11 BIRTHPLACE OF FATHER (State or country)

Maryland

12 MAIDEN NAME OF MOTHER

Mary E. Liston

13 BIRTHPLACE OF MOTHER (State or country)

Pennsylvania

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Norval Spielman

(Address)

Quadrant, Garrett Co. Md

15

Filed

May 29, 1914 Marshall B. West

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

May 26, 1914

(Month)

(Day)

(Year)

17

I HEREBY CERTIFY, That I attended deceased from

April 3, 1914, to May 26, 1914

that I last saw her alive on May 25, 1914

and that death occurred on the date stated above, at 7:30 a.m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(Duration) yrs. 2 mos. cs.

Contributory (Secondary)

Chronic Mania

(Duration) 3 yrs. 1 mos. 23 ds.

(Signed)

J. Perry Wade

M. D.

May 29, 1914

(Address)

Catonsville Md

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death

3 yrs. 1 mos. 23 ds.

In the State

39 yrs. 6 mos. 9 ds.

Where was disease contracted, If not at place of death?

Spring Grove Hospital

Former or usual residence

Oakland Md

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Garret Co. Md

May 29, 1914

20 UNDERTAKER

ADDRESS

M. Lean & Jones

833 Linden

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

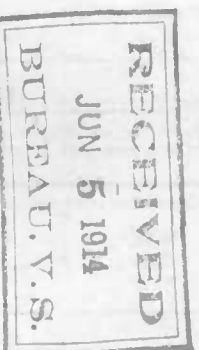
(Approved by U. S. Census and American Public Health Association.)

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationery fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not faithfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Scrub*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritonaeum*, etc., *Carcin-*

oma, *Sarcoma*, etc., of _____ (name organ; "Ovarian" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic tubercular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 da.*; *Bronchopneumonia* (secondary), *10 da.* Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congestial," "Sedle," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Typhemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "Puerperal septicemia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and quality as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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1 PLACE OF DEATH County <u>Baltimore</u> 4715		64		STATE OF MARYLAND CERTIFICATE OF DEATH	
Village or City <u>Leatonville</u> (No. <u>Spring Grove Road West</u>)		Registration Dist. No. <u>30</u>		[If death occurred in a hospital or institution, give its NAME instead of street and number.]	
2 FULL NAME <u>Regina Stachlinski</u>					
PERSONAL AND STATISTICAL PARTICULARS					
3 SEX <u>Female</u>	4 COLOR OR RACE <u>White</u>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED <u>Widowed</u> (Write the word)			
6 DATE OF BIRTH <u>unk unk</u> , 18 <u>23</u> (Month) (Day) (Year)					
7 AGE <u>91</u> yrs. <u>unk</u> mos. <u>unk</u> ds. If LESS than 1 day, hrs. OR min. ?					
8 OCCUPATION (a) Trade, profession, or particular kind of work. <u>None</u> (b) General nature of industry, business, or establishment in which employed (or employer)					
9 BIRTHPLACE (State or country) <u>Austria Poland</u>					
PARENTS	10 NAME OF FATHER <u>John Rogus</u>				
	11 BIRTHPLACE OF FATHER (State or country) <u>Poland</u>				
	12 MAIDEN NAME OF MOTHER <u>unk</u>				
	13 BIRTHPLACE OF MOTHER (State or country) <u>unk</u>				
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>John Stachlinski</u> (Address) <u>Relay, Md.</u>					
15 Filed <u>May 30</u> , 191 <u>4</u> <u>Marshall B. West</u> REGISTRAR					
MEDICAL CERTIFICATE OF DEATH					
16 DATE OF DEATH <u>May 29th</u> , 191 <u>4</u> (Month) (Day) (Year)					
17 I HEREBY CERTIFY That I attended deceased from <u>May 29th</u> , 191 <u>4</u> , to <u>May 29th</u> , 191 <u>4</u> , that I last saw him alive on <u>May 29th</u> , 191 <u>4</u> , and that death occurred on the date stated above, at <u>3:30</u> p.m. The CAUSE OF DEATH* was as follows: <u>Cerebral Hemorrhage</u> (Duration) yrs. <u>2</u> mos. <u>2</u> ds. Contributory <u>Senile Dementia</u> (Duration) yrs. <u>2</u> mos. <u>2</u> ds. (Signed) <u>Peragade</u> , M. D. <u>May 30</u> , 191 <u>4</u> (Address) <u>Leatonville, Md.</u>					
*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.					
18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS) At place of death yrs. <u>21</u> mos. <u>21</u> ds. In the State yrs. <u>21</u> mos. <u>21</u> ds. Where was disease contracted, If not at place of death? <u>Baltimore, Md.</u> Former or usual residence <u>Baltimore, Md.</u>					
19 PLACE OF BURIAL OR REMOVAL <u>St. Stanislaus</u>				DATE OF BURIAL <u>May 30</u> , 191 <u>4</u>	
20 UNDERTAKER <u>M. J. Sadowicki</u>				ADDRESS <u>705 S. Ann St.</u>	

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

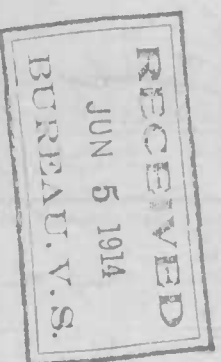
[Approved by U. S. Census and American Public Health Association.]

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Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcin-*

oma, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Retrober wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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1 PLACE OF DEATH County <u>Baltimore</u> 4717		64 STATE OF MARYLAND CERTIFICATE OF DEATH	
Village or City <u>Gowanus</u> (No. <u>Yonkers Rd</u> <u>Wallow Ave</u>)		Registration Dist. No. <u>08</u>	
2 FULL NAME <u>Mary Sullivan</u>			
PERSONAL AND STATISTICAL PARTICULARS			
3 SEX <u>F.</u>	4 COLOR OR RACE <u>W</u>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED <u>Married</u> (Write the word)	
6 DATE OF BIRTH <u>Dec 20</u> , 18 <u>88</u> (Month) (Day) (Year)			
7 AGE <u>65</u> yrs. <u>3</u> mos. <u>11</u> ds.		If LESS than 1 day.....hrs. OR.....min. ?	
8 OCCUPATION (a) Trade, profession, or particular kind of work <u>Housework</u> (b) General nature of industry, business, or establishment in which employed (or employer)			
9 BIRTHPLACE (State or country) <u>Ireland</u>			
PARENTS			
10 NAME OF FATHER <u>Wm Dwyer</u>			
11 BIRTHPLACE OF FATHER (State or country) <u>Ireland</u>			
12 MAIDEN NAME OF MOTHER <u>Mary Jordan</u>			
13 BIRTHPLACE OF MOTHER (State or country) <u>Ireland</u>			
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>Wm Sullivan</u> (Address) <u>1701 N. Fulton Ave</u>			
15 Filed <u>5/22</u> , 191 <u>4</u> <u>Charles Sullivan</u> REGISTRAR			
MEDICAL CERTIFICATE OF DEATH			
16 DATE OF DEATH <u>May 21</u> , 191 <u>4</u> (Month) (Day) (Year)			
17 I HEREBY CERTIFY, That I attended deceased from <u>Apr 10</u> , 191 <u>4</u> , to <u>May 21</u> , 191 <u>4</u> , that I last saw h <u>er</u> alive on <u>May 19</u> , 191 <u>4</u> , and that death occurred on the date stated above, at <u>11⁵⁵ 9 m.</u> The CAUSE OF DEATH* was as follows: <u>Strookplegia</u>			
Contributory (Duration) <u>Arterio Sclerosis</u> yrs. <u>1</u> mos. <u>11</u> ds.			
Secondary (Duration) <u>2</u> yrs. <u>6</u> mos. ds.			
(Signed) <u>Wm Gadden</u> , M. D. <u>5/21/14</u> , 191 <u>4</u> (Address) <u>321 E 25th St</u>			
*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.			
18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS) At place of death..... yrs. mos. ds. In the State..... yrs. mos. ds. Where was disease contracted, If not at place of death? Former or usual residence.....			
19 PLACE OF BURIAL OR REMOVAL <u>Cathedral Ave</u> DATE OF BURIAL <u>May 23</u> , 191 <u>4</u>			
20 UNDERTAKER <u>Chas H. Emuorlow</u> ADDRESS <u>118 Wmst Royal Ave</u>			

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

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Statement of cause of death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcin-*

oma, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Traemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL *septicæmia*," "PUERPERAL *peritonitis*," etc. State cause for violent deaths state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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RECEIVED
JUN 5 1914
BUREAU U. V. S.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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1 PLACE OF DEATH 4718

County BaltimoreVillage or City South Tinsan (No. 78 St. CH Ward)

2 FULL NAME

Bertha TolarSTATE OF MARYLAND
CERTIFICATE OF DEATHRegistration Dist. No. 22438

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

colored

5 SINGLE,

MARRIED, married

WIDOWED,

OR DIVORCED

(Write the word)

6 DATE OF BIRTH

Not Known

(Month)

(Day)

(Year)

7 AGE

about 35 yrs

mos.

ds.

If LESS than
1 day, hrs.
OR min.?

8 OCCUPATION

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer)

Housewife9 BIRTHPLACE
(State or country)Washington D. C.

10 NAME OF FATHER

Not known11 BIRTHPLACE OF FATHER
(State or country)Not known

12 MAIDEN NAME OF MOTHER

Not known13 BIRTHPLACE OF MOTHER
(State or country)Not known

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Henry H. Hixell

(Address)

Evans. (corner)

15

Filed

5/21, 1914 Charles Tinsan

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

May, 1914
(Month) (Day) (Year)

17

I HEREBY CERTIFY, That I attended deceased from

....., 191....., to....., 191.....
that I last saw h..... alive on....., 191.....

and that death occurred on the date stated above, at..... m.

The CAUSE OF DEATH* was as follows:

Consumption

(Duration) yrs. mos. ds.

Contributory
(Secondary)(Signed) Henry H. Hixell (Coroner)
(Duration) yrs. mos. ds.
(Address) Evans Ind.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Pleasant Rest Cem. May 21, 1914

20 UNDERTAKER

ADDRESS

John Burns Sons Towson

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative deathfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Composer*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Deputy," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—(valuing, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not actually employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcinoma*, *Sarcoma*, etc., of ----- (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*, *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.*; *Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asphyxia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congential," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Tremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "Puerperal septicemia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Reverber round of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

RECEIVED
JUN 5 1914
BUREAU, V. S.

N. B.—Every item of Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificate.

Registration Dist. No. 32

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

Village or City Washington (No. 1890 St. 1 Ward)

2 FULL NAME

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH May 22, 1916
(Month) (Day) (Year)

17 I HEREBY CERTIFY That I attended deceased from
May 22, 1914, to May 22, 1916,
still born -
that I last saw him alive on _____, 191_____

and that death occurred on the date stated above, at.....m.
The CAUSE OF DEATH* was as follows:

Still born
Cause unknown
(Duration) yrs mos ds

Contributory
(Secondary)

(Duration) yrs mos ds

(Duration) yrs. mos. ds.
(Signed) H. M. Sternson , M. D.
May 22, 1914 (Address) 1022 Mont. St. N. W.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS
OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mcs. ds.

Where was disease contracted,
If not at place of death?

Former or
usual residence.....

19 PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
<i>El Estero de Santa Cruz</i>	<i>May 23</i>
20 UNDERTAKER	ADDRESS

REGISTRAR

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

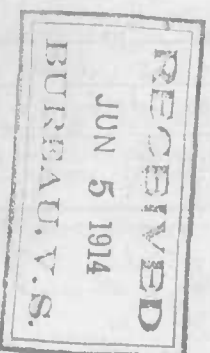
[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative wealthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry; and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Group"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritonaeum*, etc. *Carcin-*

oma, *Sarcoma*, etc., of _____ (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thma," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Hemiplegia," "Hypertension," "Old Age," "Shock," "Typhemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "Puerperal septicemia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.



WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH

4719

County Baltimore

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No. 37Village or City Harmon (No. _____ St.; _____ Ward)

[If death occurred in
a hospital or institution,
give its NAME instead
of street and number.]

2 FULL NAME Jolan Curtis Gray

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED single
(Write the word)

6 DATE OF BIRTH May 17, 1914
(Month) (Day) (Year)

7 AGE 3 yrs. 4 mos. 6 ds. If LESS than 1 day, _____ hrs. OR _____ min. ?

8 OCCUPATION
(a) Trade, profession, or particular kind of work. none
(b) General nature of industry, business, or establishment in which employed (or employer) none

9 BIRTHPLACE (State or country) Harmon Baltimore Md

10 NAME OF FATHER James L. Gasline

11 BIRTHPLACE OF FATHER (State or country) Balti: Md

12 MAIDEN NAME OF MOTHER Laura Belle Gray

13 BIRTHPLACE OF MOTHER (State or country) Baltimore Md

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Laura Belle Gray(Address) Harmon Baltimore Md

15 Filed May 25, 1914 J. B. Benson, M.D.
REGISTRAR

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH May 23, 1914
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from May 17, 1914 to May 23, 1914
that I last saw him alive on May 23, 1914

and that death occurred on the date stated above, at 5 P m.
The CAUSE OF DEATH* was as follows:

malformation of the heart
(Duration) _____ yrs. _____ mos. _____ ds.
Contributory General Debility
Secondary _____
(Duration) _____ yrs. _____ mos. 3 ds.

(Signed) D. J. Benson, M. D.
May 24, 1914 (Address) Seabrookville

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds.

Where was disease contracted,
If not at place of death? _____

Former or usual residence _____

19 PLACE OF BURIAL OR REMOVAL Popular Cemetery DATE OF BURIAL May 25, 1914

20 UNDERTAKER J. C. Brooks ADDRESS Sparks Md

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Composer*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcin-*

oma, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congential," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and qualify as ACCIDENTAL, suicidal, or homicidal, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

RECEIVED
JUN 6 1914
BUREAU, V. S.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH 4720 (169) STATE OF MARYLAND
 County Baltimore CERTIFICATE OF DEATH
 Registration Dist. No. 41
 Village or City Carlton (No. Foot of Clinton St.; Ward) [If death occurred in a hospital or institution, give its NAME instead of street and number.]
 2 FULL NAME Garfield Travers

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE Cal 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) single

6 DATE OF BIRTH unknown
 (Month) (Day) (Year)

7 AGE 20 yrs. — mos. — ds. If LESS than 1 day, — hrs. OR — min. ?

8 OCCUPATION (a) Trade, profession, or particular kind of work sailor
 (b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE (State or country) md

10 NAME OF FATHER unknown

11 BIRTHPLACE OF FATHER (State or country) unknown

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (State or country) unknown

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) none

(Address) none

15 Filed May 15, 1914 W. E. McCloskey
 REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH May 15, 1914
 (Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from 1914 to 1914

that I last saw him alive on 1914

and that death occurred on the date stated above, at m

The CAUSE OF DEATH* was as follows:

accidental drowning

(Duration) — yrs. — mos. — ds.

Contributory Secondary

(Duration) — yrs. — mos. — ds.

(Signed) A. M. M. M., M. D.

May 15, 1914 (Address) Coroner

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death — yrs. — mos. — ds. In the State — yrs. — mos. — ds.

Where was disease contracted, If not at place of death?

Former or usual residence.

19 PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

John H. H. H. May 15, 1914

UNDERTAKER ADDRESS

W. E. McCloskey 344 E. 7th St.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

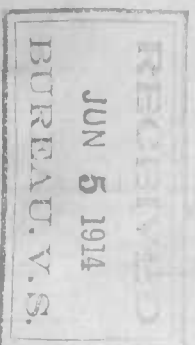
[Approved by U. S. Census and American Public Health Association.]

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Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meningis, peritoneum*, etc., *Carcin-*

oma, Sarcoma, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on nomenclature of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.



WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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1 PLACE OF DEATH 4721

County BaltimoreVillage or City Unionville

(No.)

St.; Ward)

Registration Dist. No. 160

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME Harry G. Tuckton

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Single
(Write the word)

6 DATE OF BIRTH Dec. 9, 1875
(Month) (Day) (Year)

7 AGE 38 yrs. 5 mos. 19 ds. OR 1 day, 1 hr. 5 min. ?
It LESS than 1 day, hrs. ?

8 OCCUPATION
(a) Trade, profession, or particular kind of work Salesman
(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE (State or country) Baltimore City

10 NAME OF FATHER John Tuckton

11 BIRTHPLACE OF FATHER (State or country) Harford Co. Md.

12 MAIDEN NAME OF MOTHER Sallie Currey

13 BIRTHPLACE OF MOTHER (State or country) Harford Co. Md.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Dixon Connolly(Address) Baldwin Md.

15 Filed May 20, 1914 H. F. H. Grosvenor
REGISTRAR

STATE OF MARYLAND
CERTIFICATE OF DEATH

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH May 19, 1914
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from May 15, 1914, to May 19, 1914.

that I last saw him alive on May 19, 1914.

and that death occurred on the date stated above, at 5 P. m.

The CAUSE OF DEATH* was as follows:

Tubercular meningitis

(Duration) yrs. mos. 2 ds.

Contributory Pulmonary tuberculosis
Secondary

(Duration) yrs. mos. 2 ds.

(Signed) John S. Green, M. D.

May 20, 1914. (Address) Isittings, Md.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, It not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL Wilson's Cem. Long Green Md. DATE OF BURIAL May 21st, 1914.

20 UNDERTAKER Shade Bros. ADDRESS Long Green Md.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

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DIRECTIONS—TAKE	
DR. JAS. F. H. GORSUCH	Telephone
FORK, MARYLAND	Office Hours
	Until 8.30 a. m. 12 m. to 1.30 and 6 to 8 p. m.

pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcin-*

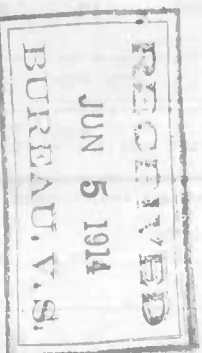
ma laborer, *Laborer*—*Coal*, who are engaged in the *y* (not paid *Housekeepers* *try*), may be entered as *at Home*, and children, not *school* or *At home*. Care specifically the occupations *istic service* for wages, as etc. If the occupation has on account of the disease *pation* at beginning of illness, that fact may be indicated *6 yrs.*) For persons *whatsoever*, write *None*.

y—Name, first, the disease *ty* affection with respect to ; always the same accepted Examples: *Cerebrospinal* *ynonym* is "Epidemic cere- *Diphtheria* (avoid use of

(never report "Typhoid

oma, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report more symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Con-fental," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL *septicæ-mia*," "PUERPERAL *peritonitis*," etc., State cause for which surgical operation was undertaken. For violent deaths state means of injury and qualify as ACCIDENTAL, suicidal, or homicidal, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—ac-cident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.



WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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1 PLACE OF DEATH 4722
County Baltimore

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No. 98

Village or City Towson (No. _____, St. _____ Ward _____)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME Mary A. Tully

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE white 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) Married

6 DATE OF BIRTH June 21, 1884
(Month) (Day) (Year)

7 AGE 19 yrs. 11 mos. 9 ds. It LESS than 1 day, ____ hrs. OR ____ min. ?

8 OCCUPATION
(a) Trade, profession, or particular kind of work House Wife
(b) General nature of industry, business, or establishment in which employed (or employer) House wife

9 BIRTHPLACE (State or country) Alex. Va.

10 NAME OF FATHER Charles M. Rudd

11 BIRTHPLACE OF FATHER (State or country) Alex. Va.

12 MAIDEN NAME OF MOTHER Elizabeth C. Jarrett

13 BIRTHPLACE OF MOTHER (State or country) New York

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Charles M. Rudd

(Address) Lutherville

15 Filed 3/21, 1914 Clara S. Smith

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH May 30, 1914
(Month) (Day) (Year)

17 I HEREBY CERTIFY that I attended deceased from May 1st, 1913 to May 30, 1914.

that I last saw her alive on May 29, 1914

and that death occurred on the date stated above, at 7.9 m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(Duration) 1 yrs. 1 mos. ____ ds.

Contributory General Tuberculosis
(Secondary)

(Duration) ____ yrs. 3 mos. ____ ds.

(Signed) J. P. Palmer, M. D.

May 30, 1914 (Address) Towson Md.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ____ yrs. ____ mos. ____ ds. In the State ____ yrs. ____ mos. ____ ds.

Where was disease contracted, If not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL Towson DATE OF BURIAL June 1, 1914

20 UNDERTAKER Mr. W. H. Burns ADDRESS Towson

John H. Burns

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

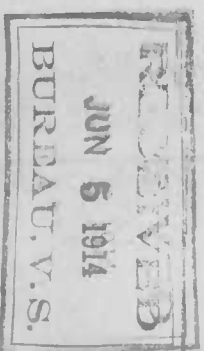
[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Composer*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer*—"oil mine", etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Loobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcin-*

oma, *Sarcoma*, etc., of ----- (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congential," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "Puerperal septicemia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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1 PLACE OF DEATH

4723

County

Balto.

Village or City

Alberton

(No.

St.;

Ward)

Registration Dist. No.

31

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME

Aisy B. Gamber Vaughan

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White

5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word)

Married

6 DATE OF BIRTH

January 22, 1892
(Month) (Day) (Year)

7 AGE

22 yrs. 2 mos. 22 ds. OR LESS than 1 day, hrs. min. ?

8 OCCUPATION

(a) Trade, profession, or particular kind of work

House Wife

(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE

(State or country)

Maryland

PARENTS

10 NAME OF FATHER

Robert Gamber

11 BIRTHPLACE OF FATHER (State or country)

Maryland

12 MAIDEN NAME OF MOTHER

Aisy R. Bowens

13 BIRTHPLACE OF MOTHER (State or country)

Maryland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Robert Gamber

(Address)

Alberton Md.

15

Filed May 14, 1914

J. N. Kemp

REGISTRAR

STATE OF MARYLAND
CERTIFICATE OF DEATH

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

May 14, 1914
(Month) (Day) (Year)

17

I HEREBY CERTIFY, That I attended deceased from

April 1, 1914, to May 14, 1914,
that I last saw her alive on May 13, 1914

and that death occurred on the date stated above, at 5:30 P. m.
The CAUSE OF DEATH* was as follows:

Tuberculosis

(Duration) yrs. 6 mos. ds.

Contributory
Secondary

Cardiac weakness

(Duration) yrs. 1 mos. ds.

(Signed)

W. N. Garrison, M. D.

May 14, 1914 (Address) Alberton Md.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, If not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Deer Park Cemetery

May 17, 1914

20 UNDERTAKER

ADDRESS

S. Hillinger & Son

Baltimore City

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not faintly employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcin-*

oma, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Con- genital," "Senile" etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Maras- mus," "Old Age," "Shock," "Træmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal *septicæmia*," "Puerperal *peritonitis*," etc. State cause for which surgical operation was undertaken. For vio- LENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—acci- dent*; *Revolver wound of head—homicide*; *Poisoned by carboic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomencla- ture of the American Medical Association.)

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RECEIVED
MAY 26 1914
BUREAU, V. S.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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1 PLACE OF DEATH <u>4724</u>		STATE OF MARYLAND CERTIFICATE OF DEATH	
County <u>Balto</u>		Registration Dist. No. <u>41</u>	
Village or City <u>Highlandtown</u> (No. <u>432 S. 7th</u>)		St. _____ Ward _____	
2 FULL NAME <u>Daniel Vettel</u>		[If death occurred in a hospital or institution, give its NAME instead of street and number.]	
PERSONAL AND STATISTICAL PARTICULARS		MEDICAL CERTIFICATE OF DEATH	
3 SEX <u>Male</u>	4 COLOR OR RACE <u>White</u>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) <u>Single</u>	
6 DATE OF BIRTH <u>Mar 27th</u> , 191 <u>4</u> (Month) (Day) (Year)		16 DATE OF DEATH <u>May 18</u> , 191 <u>4</u> (Month) (Day) (Year)	
7 AGE ____ yrs. <u>1</u> mos. <u>18</u> ds. If LESS than 1 day, ____ hrs. OR ____ min. ?		17 I HEREBY CERTIFY, That I attended deceased from <u>May 14</u> , 191 <u>4</u> , to <u>May 16</u> , 191 <u>4</u> , that I last saw him alive on <u>May 15</u> , 191 <u>4</u> , and that death occurred on the date stated above, at <u>2:50</u> p.m. The CAUSE OF DEATH* was as follows: <u>Inanition</u>	
8 OCCUPATION (a) Trade, profession, or particular kind of work (b) General nature of industry, business, or establishment in which employed (or employer) <u>None</u>		Contributory (Secondary) <u>7 month Premature delivery</u> (Duration) ____ yrs. ____ mos. ____ ds.	
9 BIRTHPLACE (State or country) <u>City</u>		(Signed) <u>S. A. Slantz</u> , M. D. <u>May 18</u> , 191 <u>4</u> (Address) <u>3244 Eastern Ave</u>	
PARENTS	10 NAME OF FATHER <u>Theo. Vettel</u>	*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.	
	11 BIRTHPLACE OF FATHER (State or country) <u>Md</u>	18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS) At place of death ____ yrs. ____ mos. ____ ds. In the State ____ yrs. ____ mos. ____ ds.	
	12 MAIDEN NAME OF MOTHER <u>Anna V. Wollenmaier</u>	Where was disease contracted, If not at place of death? Former or usual residence.	
13 BIRTHPLACE OF MOTHER (State or country) <u>Md</u>		19 PLACE OF BURIAL OR REMOVAL <u>Oak Lawn</u>	
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE Informant, <u>Theo. Vettel</u> (Address) <u>432 S. 7th St</u>		DATE OF BURIAL <u>May 18</u> , 191 <u>4</u>	
15 Filed <u>May 18</u> , 191 <u>4</u> <u>W. E. McLaughlin</u> REGISTRAR <u>M. D.</u>		20 UNDERTAKER <u>Philip Herwig</u>	
		ADDRESS <u>2016 Orleans</u>	

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

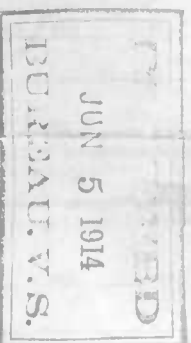
[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Composer*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritonaeum*, etc.. *Carcin-*

oma, *Sarcoma*, etc., of _____ (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.*; *Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congential," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent DEATHS state MEANS OF INJURY and quality as ACCIDENTAL, suicidal, or homicidal, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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1 PLACE OF DEATH <u>4725</u>			(91) STATE OF MARYLAND CERTIFICATE OF DEATH Registration Dist. No. <u>144</u>	
County <u>Baltimore</u>				
Village or City <u>Spinnier Point</u> (No. _____, <u>Edgemere</u> St.; _____ Ward)			[It death occurred in a hospital or institution, give its NAME instead of street and number.]	
2 FULL NAME <u>Charles Wagner</u>				
PERSONAL AND STATISTICAL PARTICULARS				
3 SEX <u>Male</u>	4 COLOR OR RACE <u>White</u>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) <u>Single</u>		
6 DATE OF BIRTH <u>Unknown</u> , 1840 (Month) (Day) (Year)				
7 AGE <u>about 74</u> yrs. _____ mos. _____ ds.		If LESS than 1 day, _____ hrs. _____ min. ?		
8 OCCUPATION (a) Trade, profession, or particular kind of work <u>Fisherman</u> (b) General nature of industry, business, or establishment in which employed (or employer) <u>Fisherman</u>				
9 BIRTHPLACE (State or country) <u>Unknown</u>				
PARENTS	10 NAME OF FATHER <u>Unknown</u>			
	11 BIRTHPLACE OF FATHER (State or country) <u>Germany</u>			
	12 MAIDEN NAME OF MOTHER <u>Unknown</u>			
	13 BIRTHPLACE OF MOTHER (State or country) <u>Germany</u>			
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>John Deboy</u> (Address) <u>Shell Road, Balt. Co.</u>				
15 Filed <u>May 9th</u> , 1914 <u>G. J. McFormica, M.D.</u> REGISTRAR				
MEDICAL CERTIFICATE OF DEATH				
16 DATE OF DEATH <u>May 8th</u> , 1914 (Month) (Day) (Year)				
17 I HEREBY CERTIFY, That I attended deceased from <u>May 28th</u> , 1914, to <u>May 8th</u> , 1914, that I last saw him alive on <u>May 7th</u> , 1914, and that death occurred on the date stated above, at <u>1230 A.M.</u> , The CAUSE OF DEATH* was as follows: <u>Bronchitis Pneumonia</u>				
Contributory (Duration) _____ yrs. _____ mos. <u>10</u> ds. Secondary <u>Polymia</u>				
(Signed) <u>F. C. Elder</u> , M. D. <u>May 8th</u> , 1914. (Address) <u>Spinnier Point</u>				
*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.				
18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS) At place of death _____ yrs. _____ mos. _____ ds. In the _____ State _____ yrs. _____ mos. _____ ds. Where was disease contracted, _____ It not at place of death? _____ Former or usual residence _____				
19 PLACE OF BURIAL OR REMOVAL <u>Mount Carmel Cem.</u>			DATE OF BURIAL <u>May 10th</u> , 1914	
20 UNDERTAKER <u>Lilly & Ziller</u>			ADDRESS <u>403 S. Wolfe St.</u>	

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

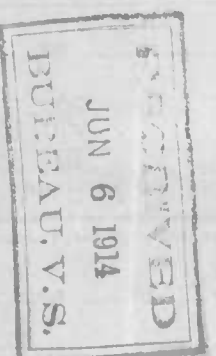
[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Saltman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not faithfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcin-*

oma, Sarcoma, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal, septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and qualify as ACCIDENTAL, suicidal, or homicidal, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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1 PLACE OF DEATH County <u>Baltimore</u>		4726		(120)		STATE OF MARYLAND CERTIFICATE OF DEATH	
Village or City <u>Catonsville</u> (No. <u>Spring Grove Hospital</u> Ward)		2 FULL NAME <u>Juliette A. Warren</u>		Registered No. <u>30</u>		[If death occurred in a hospital or institution, give its NAME instead of street and number.]	
PERSONAL AND STATISTICAL PARTICULARS							
3 SEX <u>Female</u>		4 COLOR OR RACE <u>White</u>		5 SINGLE, MARRIED, WIDOWED, OR DIVORCED <u>widow</u> (Write the word)			
6 DATE OF BIRTH <u>unknown</u>		(Month) (Day) (Year)		7 AGE <u>79</u> yrs. mos. ds. If LESS than 1 day, hrs. OR min. ?			
8 OCCUPATION (a) Trade, profession, or particular kind of work (b) General nature of industry, business, or establishment in which employed (or employer)		<u>None</u> <u>None</u>					
9 BIRTH PLACE (State or country)		<u>Maryland</u>					
PARENTS	10 NAME OF FATHER		<u>unknown</u>				
	11 BIRTH PLACE OF FATHER (State or country)		<u>unknown</u>				
	12 MAIDEN NAME OF MOTHER		<u>unknown</u>				
	13 BIRTH PLACE OF MOTHER (State or country)		<u>unknown</u>				
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>Taken from Hospital</u> (Address) <u>Records - incomplete</u>							
15 Filed <u>May 20</u> , 1914 <u>Marshall B. Burt</u>		REGISTRAR					
MEDICAL CERTIFICATE OF DEATH							
16 DATE OF DEATH <u>May 19</u> , 1914 (Month) (Day) (Year)		17 I HEREBY CERTIFY, That I attended deceased from <u>October 1, 1896</u> to <u>May 19</u> , 1914 that I last saw her alive on <u>May 18</u> , 1914 and that death occurred on the date stated above, at <u>8:20 p.m.</u> The CAUSE OF DEATH* was as follows:					
<u>manic-depressive insanity</u> (Duration) <u>26</u> yrs. <u>6</u> mos. <u>4</u> ds. Contributory <u>Chronic Bright's Disease</u> (Secondary) (Duration) <u>5</u> yrs. mos. ds. (Signed) <u>J. Percy Wade</u> , M. D. <u>May 20</u> , 1914 (Address) <u>Catonsville Md</u>							
*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.							
18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS) At place of death <u>26</u> yrs. <u>6</u> mos. <u>4</u> ds. to the State <u>26</u> yrs. mos. ds. Where was disease contracted, <u>Denton Md.</u> If not at place of death? Former or usual residence <u>Denton Md.</u>							
19 PLACE OF BURIAL OR REMOVAL <u>Betterton Kent Co. Md.</u>				DATE OF BURIAL <u>May 20</u> , 1914.			
20 UNDERTAKER <u>H. C. Wiedefeld</u>				ADDRESS <u>914 Green Mt.</u>			

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

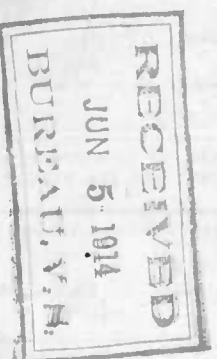
[Approved by U. S. Census and American Public Health Association.]

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Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritonaeum*, etc. *Carcin-*

oma, *Sarcoma*, etc., of _____ (name organ; "Ovarian" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.*; *Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "Puerperal septicemia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and quality as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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1 PLACE OF DEATH County <u>Baltimore</u>		4727	120	STATE OF MARYLAND CERTIFICATE OF DEATH	
Village or City <u>Woodlawn</u>		(No.)	St.; Ward		Registration Dist. No. <u>31</u>
2 FULL NAME <u>Annie Mary Hebel</u>					
PERSONAL AND STATISTICAL PARTICULARS					
3 SEX <u>Female</u>	4 COLOR OR RACE <u>White</u>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED <u>Widowed</u> (Write the word)			
6 DATE OF BIRTH <u>April 9, 1840</u> (Month) (Day) (Year)					
7 AGE <u>74</u> yrs. <u>1</u> mos. <u>7</u> ds. OR <u>1</u> day, <u>7</u> hrs. <u>7</u> min. ? If LESS than 1 day, hrs. min. ?					
8 OCCUPATION (a) Trade, profession, or particular kind of work <u>Domestic Duties</u> (b) General nature of industry, business, or establishment in which employed (or employer)					
9 BIRTHPLACE (State or country) <u>Germany</u>					
PARENTS	10 NAME OF FATHER <u>Adam Grimm</u>				
	11 BIRTHPLACE OF FATHER (State or country) <u>Germany</u>				
	12 MAIDEN NAME OF MOTHER <u>Annie Mary Grimm</u>				
13 BIRTHPLACE OF MOTHER (State or country) <u>Germany</u>					
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>Jos. Louis W. Stawitz</u> (Address) <u>Woodlawn</u>					
15 Filed <u>May 17, 1914</u> <u>H. J. O'Leary</u> REGISTRAR					
MEDICAL CERTIFICATE OF DEATH					
18 DATE OF DEATH <u>May 16, 1914</u> (Month) (Day) (Year)					
17 I HEREBY CERTIFY, That I attended deceased from <u>May 14, 1914</u> , to <u>May 16, 1914</u> , that I last saw <u>her</u> alive on <u>May 15, 1914</u> , and that death occurred on the date stated above, at <u>12</u> m. The CAUSE OF DEATH* was as follows: <u>Chronic Parenchymatous Nephritis</u> <u>Do not know</u> (Duration) yrs. mos. ds.					
Contributory Secondary (Duration) yrs. mos. ds.					
(Signed) <u>Wm. E. Martin</u> , M. D. <u>May 17, 1914</u> . (Address) <u>Roslyn, Md.</u>					
*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.					
18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS) At place of death yrs. mos. ds. In the State yrs. mos. ds. Where was disease contracted, If not at place of death? Former or usual residence					
19 PLACE OF BURIAL OR REMOVAL <u>Landon Park</u>					DATE OF BURIAL <u>May 19, 1914</u>
20 UNDERTAKER <u>Easton Sons</u>					ADDRESS <u>Ellicott City</u>

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

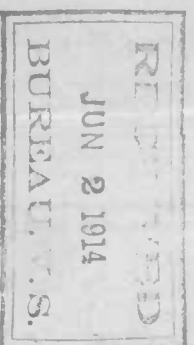
[Approved by U. S. Census and American Public Health Association.]

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Statement of cause of death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Group"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritonaeum*, etc., *Carcin-*

oma, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on Statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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1 PLACE OF DEATH <u>4728</u>		STATE OF MARYLAND CERTIFICATE OF DEATH	
County <u>Baltimore</u>		Registration Dist. No. <u>30</u>	
Village or City <u>Catonville</u> (No. <u>Spring Lane St.</u> Ward <u>1st</u>)		[If death occurred in a hospital or institution, give its NAME instead of street and number.]	
2 FULL NAME <u>Rosa L Webster</u>			
PERSONAL AND STATISTICAL PARTICULARS			
3 SEX <u>Female</u>	4 COLOR OR RACE <u>white</u>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED <u>Married</u> (Write the word)	
6 DATE OF BIRTH <u>March 1st, 1880</u> (Month) (Day) (Year)			
7 AGE <u>34</u> yrs. <u>10</u> mos. <u>10</u> ds.		It LESS than 1 day, hrs. OR min. ?	
8 OCCUPATION (a) Trade, profession, or particular kind of work <u>Housewife</u> (b) General nature of industry, business, or establishment in which employed (or employer)			
9 BIRTHPLACE (State or country) <u>Maryland</u>			
PARENTS	10 NAME OF FATHER <u>John</u>		
	11 BIRTHPLACE OF FATHER (State or country) <u>Maryland</u>		
	12 MAIDEN NAME OF MOTHER <u>Webster</u>		
13 BIRTHPLACE OF MOTHER (State or country) <u>Maryland</u>			
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>Linville C. Webster</u> (Address) <u>Byattsville Md</u>			
15 Filed <u>May 14, 1914</u> <u>Marshall B West</u> REGISTRAR			
MEDICAL CERTIFICATE OF DEATH			
16 DATE OF DEATH <u>May 7th</u> , 191 <u>4</u> (Month) (Day) (Year)			
17 I HEREBY CERTIFY, That I attended deceased from <u>Nov 18th 1918</u> to <u>May 7th</u> , 191 <u>4</u> , that I last saw h. <u>alive</u> on <u>May 7th</u> , 191 <u>4</u> , and that death occurred on the date stated above, at <u>4 P</u> m. The CAUSE OF DEATH* was as follows: <u>Pulmonary Tuberculosis</u> (Duration) <u>6</u> yrs. <u>6</u> mos. <u>6</u> ds.			
Contributory Secondary (Duration) <u>6</u> yrs. <u>6</u> mos. <u>6</u> ds.			
(Signed) <u>J. Percy Wade</u> , M. D. <u>May 9th</u> , 191 <u>4</u> (Address) <u>Catonville Md</u>			
*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.			
18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS) At place of death <u>5</u> yrs. <u>6</u> mos. <u>10</u> ds. In the State <u>5</u> yrs. <u>6</u> mos. <u>10</u> ds. Where was disease contracted, If not at place of death Former or usual residence <u>Prince George Co. Md</u>			
19 PLACE OF BURIAL OR REMOVAL <u>Spring Lane State Hosp</u>		DATE OF BURIAL <u>May 11th</u> , 191 <u>4</u>	
20 UNDERTAKER <u>Spring Lane State Hosp</u>		ADDRESS <u>Catonville Md</u>	

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

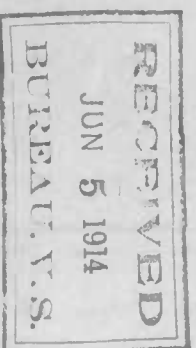
[Approved by U. S. Census and American Public Health Association.]

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Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcin-*

oma, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-theia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Typhemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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1 PLACE OF DEATH 4729
County Baltimore

Village or City Lutherville (No. _____) St.; _____ Ward) _____

2 FULL NAME Still BirthSTATE OF MARYLAND
CERTIFICATE OF DEATHRegistration Dist. No. 38

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE Col 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Single
(Write the word)

6 DATE OF BIRTH May 3, 1914
(Month) (Day) (Year)

7 AGE Still Birth If LESS than 1 day, _____ hrs. _____ min. ?
yrs. mos. ds. OR

8 OCCUPATION
(a) Trade, profession, or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer) None

9 BIRTHPLACE (State or country) Mo.

PARENTS
10 NAME OF FATHER Thomas Means
11 BIRTHPLACE OF FATHER (State or country) Mo.
12 MAIDEN NAME OF MOTHER Florence Taylor
13 BIRTHPLACE OF MOTHER (State or country) Mo.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Thomas Means
(Address) Lutherville Mo.

15 Filed 5/4, 1914 Claud Sauer
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH May 3, 1914
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from Still Birth 1914 to Birth 1914,
that I last saw h Still Birth 1914

and that death occurred on the date stated above, at _____ m.

The CAUSE OF DEATH* was as follows:

Still Birth
(Duration) _____ yrs. _____ mos. _____ ds.

Contributory Still Birth
Secondary

(Signed) J. R. Rogers M. D.
May 3, 1914 (Address) Crofton Mo.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds.

Where was disease contracted, If not at place of death? _____

Former or usual residence _____

19 PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Pleasant Rest Cemetery May 5th, 1914

20 UNDERTAKER ADDRESS

Johny Burns Sons Towson

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

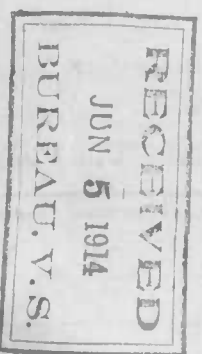
[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcin-*

oma, Sarcoma, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congential," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railroad train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.



WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH

4730

County BaltimoreSTATE OF MARYLAND
CERTIFICATE OF DEATHRegistration Dist. No. 429Village or City St. Agnes Hospital (No. _____)

St. _____ Ward _____

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME

James W. Wharry

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White5 SINGLE,
MARRIED,
WIDOWED,
ORDIVORCED
(Write the word)Single

6 DATE OF BIRTH

March 13, 1914
(Month) (Day) (Year)

7 AGE

yrs. 2 mos. 7 ds. OR 1 day, _____ hrs. _____ min. ?

8 OCCUPATION

(a) Trade, profession, or particular kind of work

Infant

(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE

(State or country)

Miss.

PARENTS

10 NAME OF FATHER

James M. Wharry11 BIRTHPLACE OF FATHER
(State or country)Baltimore Md.

12 MAIDEN NAME OF MOTHER

Katherine Conrad13 BIRTHPLACE OF MOTHER
(State or country)Baltimore Md.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs. James Wharry(Address) 1 Memphis Lane

15

Filed May 21, 1914 Goldsmith

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

May 19, 1914
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from

May 14, 1914 to May 19, 1914.that I last saw him alive on May 19, 1914.and that death occurred on the date stated above, at 10:15 p. m.

The CAUSE OF DEATH* was as follows:

Murder(Duration) yrs. 1 mos. ? ds.Contributory
Secondary(Duration) ? yrs. _____ mos. _____ ds.(Signed) Walter G. Estrudorf, M. D.May 19, 1914 (Address) St. Agnes Hospital

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death _____ yrs. _____ mos. 5 ds. In the State _____ yrs. _____ mos. _____ ds.

Where was disease contracted, if not at place of death?

Former or usual residence 1 Memphis Lane

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

St. Agnes HospitalMay 21, 1914

20 UNDERTAKER

ADDRESS

C. H. McCormick1729 M. Lane

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

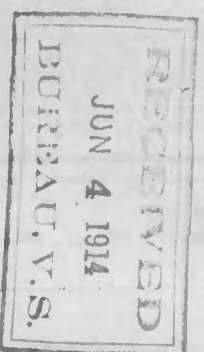
[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcin-*

oma, Sarcoma, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal, septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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1 PLACE OF DEATH <u>4731</u>		STATE OF MARYLAND	
County <u>Baltimore</u>		CERTIFICATE OF DEATH	
Village or City <u>Awings Mills</u> (No. <u>Rosewood State Training School</u>)		Registration Dist. No. <u>33</u>	
2 FULL NAME <u>Carl S. Whipp</u>		[If death occurred in a hospital or institution, give its NAME instead of street and number.]	
PERSONAL AND STATISTICAL PARTICULARS			
3 SEX <u>Male</u>	4 COLOR OR RACE <u>White</u>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED <u>Single</u> (Write the word)	
6 DATE OF BIRTH <u>April 13th, 1898</u> (Month) (Day) (Year)			
7 AGE <u>16 yrs. 1 mos. 7 ds.</u>		If LESS than 1 day.....hrs. OR.....min. ?	
8 OCCUPATION (a) Trade, profession, or particular kind of work <u>mate of State Instn</u> (b) General nature of industry, business, or establishment in which employed (or employer) <u>for the Feeble Minded</u>			
9 BIRTHPLACE (State or country) <u>Maryland</u>			
PARENTS	10 NAME OF FATHER <u>J. M. Whipp</u>		
	11 BIRTHPLACE OF FATHER (State or country) <u>Maryland</u>		
	12 MAIDEN NAME OF MOTHER <u>Mollie R. Myers</u>		
	13 BIRTHPLACE OF MOTHER (State or country) <u>Maryland</u>		
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>Frank W. Keating</u> (Address) <u>Awings Mills, Md</u>			
15 Filed <u>May 20, 1914</u> <u>J. F. Colins</u> REGISTRAR			
MEDICAL CERTIFICATE OF DEATH			
16 DATE OF DEATH <u>May 20th, 1914</u> (Month) (Day) (Year)			
17 I HEREBY CERTIFY, That I attended deceased from <u>July 11, 1911</u> to <u>May 20, 1914</u> that I last saw him alive on <u>May 20, 1914</u> and that death occurred on the date stated above, at <u>11:5 a. m.</u> The CAUSE OF DEATH* was as follows: <u>Status Epilepticus</u> (Duration)yrs.mos. <u>1</u> ds. Contributory Secondary (Duration)yrs.mos.ds. (Signed) <u>Frank W. Keating, M. D.</u> <u>May 20, 1914</u> (Address) <u>Awings Mills, Md</u> *State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.			
18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS) At place of death <u>2 yrs. 10 mos. 9 ds.</u> In the <u>16 yrs. 1 mos. 7 ds.</u> Where was disease contracted, <u>Fredonch, Md</u> If not at place of death? Former or usual residence <u>Fredonch, Md</u>			
19 PLACE OF BURIAL OR REMOVAL <u>St Mathews Church</u>		DATE OF BURIAL <u>May 21, 1914</u>	
20 UNDERTAKER <u>J. F. Colins</u>		ADDRESS <u>Reisterstown Md</u>	

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

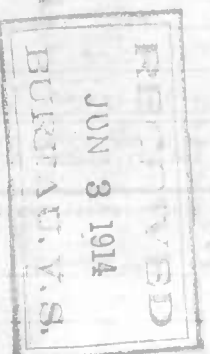
[Approved by U. S. Census and American Public Health Association.]

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Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcin-*

oma, Sarcoma, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intervening) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congential," "Senile" etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Traemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL *septicæmia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For violent deaths state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railroad train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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1 PLACE OF DEATH 4732
 County Baltimore
 Village or City Catonsville (No. Five Oaks Fredrick Ave. Ward)
 Registration Dist. No. 30
 2 FULL NAME Rosina Vick

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) Married

6 DATE OF BIRTH Oct. 27th, 1855
 (Month) (Day) (Year)

7 AGE 58 yrs. 6 mos. 24 ds. OR LESS than 1 day, hrs. OR min. ?

8 OCCUPATION
 (a) Trade, profession, or particular kind of work House Wives
 (b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE (State or country) Baltimore Md.

10 NAME OF FATHER Balthasar Schneider

11 BIRTHPLACE OF FATHER (State or country) Germany

12 MAIDEN NAME OF MOTHER Elizabeth Kraus

13 BIRTHPLACE OF MOTHER (State or country) Germany

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs. A. Waldeck
 (Address) Catonsville Md.

15 Filed May 20, 1914 Marshall B. Woot
 REGISTRAR

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

43 STATE OF MARYLAND
 CERTIFICATE OF DEATH

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH May 20th, 1914
 (Month) (Day) (Year)

17 I HEREBY CERTIFY that I attended deceased from April 19, 1914, to May 20, 1914, that I last saw her alive on May 20, 1914,

and that death occurred on the date stated above, at 6⁴⁵ P. M.

The CAUSE OF DEATH* was as follows:
Carcinoma of Left Breast

(Duration) 1 yrs. — mos. — ds.
 Contributory (Secondary) Stomach Poison

(Duration) 4 yrs. — mos. — ds.
 (Signed) Marshall B. Woot, M. D.
May 20, 1914 (Address) Catonsville Md.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death — yrs. — mos. — ds. In the State — yrs. — mos. — ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL London Park Cemetery DATE OF BURIAL May 25, 1914

20 UNDERTAKER Mrs. Mrs. John H. Poupel 801 N. Fayette St. ADDRESS

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

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Statement of cause of death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc. *Carcin-*

oma, *Sarcoma*, etc., of _____ (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 *ds.*; *Bronchopneumonia* (secondary), 10 *ds.* Never report mere symptoms or terminal conditions, such as "Anaethesia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congential," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be sketched under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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RECEIVED

JUN 5 1914

BUREAU, U. S.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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1 PLACE OF DEATH 4733
County Baltimore

Village or City Canton (No. 919, S. East Ave Ward)

2 FULL NAME Frederick Wille

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No. 41

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) Married

6 DATE OF BIRTH Nov. 5, 1845
(Month) (Day) (Year)

7 AGE 68 yrs. 6 mos. 25 ds. OR LESS than 1 day, ____ hrs. ____ min. ?

8 OCCUPATION
(a) Trade, profession, or particular kind of work Day laborer
(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE (State or country) Germany

10 NAME OF FATHER Not known

11 BIRTHPLACE OF FATHER (State or country) Not known

12 MAIDEN NAME OF MOTHER Not known

13 BIRTHPLACE OF MOTHER (State or country) Not known

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Elizabeth Wille

(Address) 919 S. East Ave

15 Filed June 2, 1914 W. E. McLaughlin

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH May 30, 1914
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from May 28, 1914, to May 30, 1914, that I last saw him alive on May 30, 1914

and that death occurred on the date stated above, at 6:20 P. m.

The CAUSE OF DEATH* was as follows:

Arterio Sclerosis
(Duration) ____ yrs. ____ mos. ____ ds.

Contributory Cerebral Hemorrhage
Secondary (Duration) ____ yrs. ____ mos. 3 ds.

(Signed) W. J. McQuay, M. D.
June 1, 1914 (Address) 859 S. Ellwood Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ____ yrs. ____ mos. ____ ds. In the State ____ yrs. ____ mos. ____ ds.

Where was disease contracted, It not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL Oak Lawn Cem. DATE OF BURIAL June 3, 1914

20 UNDERTAKER Girkler + Girkler ADDRESS 3204 O'Donnell

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

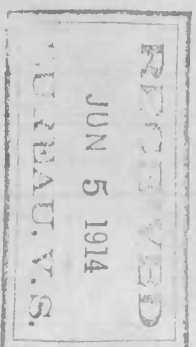
[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Former (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcin-*

oma, Sarcoma, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congential," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Hæmiplegia," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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4734

1 PLACE OF DEATH

County Baltimore Co

Village or City

Relay

(No. _____)

St. _____

Ward _____

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

STATE OF MARYLAND
CERTIFICATE OF DEATHRegistration Dist. No. 30

2 FULL NAME

George Frederick August Wabous

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 SINGLE,

MARRIED,

WIDOWED,

OR DIVORCED

(Write the word)

Married

6 DATE OF BIRTH

June 17, 1832

(Month)

(Day)

(Year)

7 AGE

60 yrs. 11 mos. ds.

If LESS than

1 day, _____ hrs.

OR _____ min. ?

8 OCCUPATION

(a) Trade, profession, or particular kind of work.

Hotel & Restaurant Proprietor

(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE
(State or country)Germany

10 NAME OF FATHER

George Wabous11 BIRTHPLACE OF FATHER
(State or country)Germany

12 MAIDEN NAME OF MOTHER

Minnie Depkin13 BIRTHPLACE OF MOTHER
(State or country)Germany

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Mrs. Matala L. Wabous

(Address)

Relay, Balto Co Md

15

Filed

May 10, 1914Marshall B. West

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

May 8, 1914

(Month)

(Day)

(Year)

17

I HEREBY CERTIFY, That I attended deceased from

Dec 12, 1913, to May 8, 1914,that I last saw him alive on May 7, 1914and that death occurred on the date stated above, at 6:15 a. m.

The CAUSE OF DEATH* was as follows:

Chronic atrophy of the digestive organs
due to loss of weight
due to alcohol for 40 years
(Duration) 3 yrs. mos. ds.

Contributory

Secondary

(Duration) 3 yrs. mos. ds.(Signed) Arthur Williams, M. D.April 8, 1914 (Address) Elk Ridge Md

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place

of death

_____ yrs. _____ mos. _____ ds.

In the

State

_____ yrs. _____ mos. _____ ds.

Where was disease contracted, If not at place of death?

Former or

usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Louisa MdMay 9, 1914

20 UNDERTAKER

ADDRESS

Wm. BeckwithNorth Ave

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

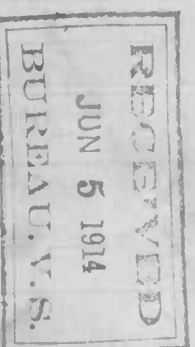
[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mining*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Former (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meningis, peritonacum*, etc., *Carcin-*

oma, Sarcoma, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For violent DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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1 PLACE OF DEATH County <u>Baltimore</u>		4735	(120)	STATE OF MARYLAND CERTIFICATE OF DEATH	
Village or City <u>Belmont Park</u> (No. <u>5</u> <u>Upland Road</u> ; Ward)		Registration Dist. No. <u>38</u>		[If death occurred in a hospital or institution, give its NAME instead of street and number.]	
2 FULL NAME <u>James Savage Woodward</u>					
PERSONAL AND STATISTICAL PARTICULARS					
3 SEX <u>Male</u>	4 COLOR OR RACE <u>White</u>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) <u>Married</u>			
6 DATE OF BIRTH <u>July 25</u> , 18 <u>84</u> (Month) (Day) (Year)					
7 AGE <u>59</u> yrs. <u>10</u> mos. <u>3</u> ds. If LESS than 1 day,.....hrs. OR.....min.?					
8 OCCUPATION (a) Trade, profession, or particular kind of work <u>Physician</u> (b) General nature of industry, business, or establishment in which employed (or employer)					
9 BIRTHPLACE (State or country) <u>District of Columbia</u>					
PARENTS	10 NAME OF FATHER <u>James Woodward</u>				
	11 BIRTHPLACE OF FATHER (State or country) <u>District of Columbia</u>				
	12 MAIDEN NAME OF MOTHER <u>Mary Savage</u>				
13 BIRTHPLACE OF MOTHER (State or country) <u>District of Columbia</u>					
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>R. H. Hussey</u> (Address) <u>5 Upland Road Belmont Park</u>					
15 Filed <u>May 29</u> , 191 <u>4</u> <u>Deputy Local</u> REGISTRAR					
MEDICAL CERTIFICATE OF DEATH					
16 DATE OF DEATH <u>May 28</u> , 191 <u>4</u> (Month) (Day) (Year)					
17 I HEREBY CERTIFY, That I attended deceased from <u>May 25</u> , 191 <u>4</u> , to <u>May 28</u> , 191 <u>4</u> , that I last saw him alive on <u>May 28</u> , 191 <u>4</u> , and that death occurred on the date stated above, at <u>7:10 a.m.</u> , The CAUSE OF DEATH* was as follows: <u>Chronic interstitial nephritis</u> <u>Chronic diffuse arteriosclerosis</u> (Duration) <u>several</u> yrs. mos. ds.					
Contributory Secondary (Duration) yrs. mos. ds.					
(Signed) <u>R. H. Hussey</u> <u>May 28</u> , 191 <u>4</u> . (Address) <u>5 Upland Road Belmont Park, Md.</u>					
*State the DISEASE CAUSING DEATH, if known, from VITAL CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, OR HOMICIDAL.					
18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS) At place of death <u>5</u> yrs. mos. ds. In the State <u>35</u> yrs. mos. ds. Where was disease contracted, if not at place of death? Former or usual residence <u>5 Upland Road Belmont Park, Md.</u>					
19 PLACE OF BURIAL OR REMOVAL <u>Washington, D.C.</u> DATE OF BURIAL <u>May 30th</u> , 191 <u>4</u>					
20 UNDERTAKER <u>H. W. Jenkins & Son, Co.</u> ADDRESS <u>Baltimore, Md.</u>					
If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.					

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

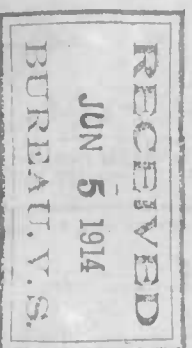
[Approved by U. S. Census and American Public Health Association.]

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Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcin-*

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1 PLACE OF DEATH

4736

County BaltimoreVillage or City St. Agnes Hospital (No. _____)

St. _____ Ward _____

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME

Mr. Shepard WylieRegistration Dist. No. 72

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White5 SINGLE,
MARRIED,
WIDOWED,
OR DIVORCED
(Write the word) Married

6 DATE OF BIRTH

— — 1857
(Month) (Day) (Year)

7 AGE

56 yrs. — mos. — ds. OR — min. ?
If LESS than 1 day, hrs.

8 OCCUPATION

(a) Trade, profession, or particular kind of work

Machinist

(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE

(State or country)

Ireland

PARENTS

10 NAME OF FATHER

James Wylie11 BIRTHPLACE OF FATHER
(State or country)Ireland

12 MAIDEN NAME OF MOTHER

Elizabeth McCord13 BIRTHPLACE OF MOTHER
(State or country)England

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mr. S. Wylie(Address) 419 S. Parrish St.

15

Filed May 10 1914 Godthorpe

REGISTRAR

STATE OF MARYLAND
CERTIFICATE OF DEATH

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

May 10, 1914
(Month) (Day) (Year)

17 I HEREBY CERTIFY, that I attended deceased from

Apr. 13, 1914, to May 10, 1914,
that I last saw him alive on May 10, 1914and that death occurred on the date stated above, at 1 p. m.

The CAUSE OF DEATH* was as follows:

Cerebral Anemia(Duration) 10 yrs. — mos. — ds.Contributory
SecondaryAcute dilatation of Heart(Duration) ? yrs. — mos. — ds.(Signed) Walter G. Osterdorf, M. D.May 10, 1914 (Address) St. Agnes Hospital

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death — yrs. — mos. 27 ds. In the State — yrs. — mos. — ds.

Where was disease contracted, If not at place of death?

Former or usual residence 419 S. Parrish St.

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Leaden ParkMay 13, 1914

20 UNDERTAKER

ADDRESS

Wm. Cochr.502 B. Northern

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

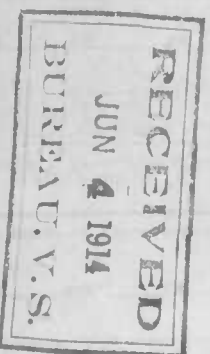
[Approved by U. S. Census and American Public Health Association.]

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Statement of cause of death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcin-*

oma, Sarcoma, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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1 PLACE OF DEATH

County Baltimore

4737

STATE OF MARYLAND
CERTIFICATE OF DEATHRegistration Dist. No. 4Village or City Canton (No. 1621 Clinton St.; Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME

Charles Yeager

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White5 SINGLE,
MARRIED,
WIDOWED,
ORDIVORCED
(Write the word)Single

6 DATE OF BIRTH

May 25, 1 (Year)
(Month) (Day)

7 AGE

48 yrs. — mos. — ds. If LESS than
1 day, hrs. OR min. ?

8 OCCUPATION

(a) Trade, profession, or particular kind of work

Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE
(State or country)Maryland

PARENTS

10 NAME OF FATHER

Anton Yeager11 BIRTHPLACE OF FATHER
(State or country)Germany

12 MAIDEN NAME OF MOTHER

Catharine Schmidt13 BIRTHPLACE OF MOTHER
(State or country)Germany

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Mrs. Kappeler

(Address)

1525 Eastern Ave.

15

Filed

May 13, 1914W. H. McClanahan

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

May 13, 1914
(Month) (Day) (Year)17 I HEREBY CERTIFY, That I attended deceased from
_____, 191____, to _____, 191____,

that I last saw him alive on _____, 191____

and that death occurred on the date stated above, at _____ m.

The CAUSE OF DEATH* was as follows:

Heart Failure

(Duration) _____ yrs. _____ mos. _____ ds.

Contributory
Secondary

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed)

A. S. Warner, M. D.May 13, 1914. (Address) Coroner

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds.

Where was disease contracted,
If not at place of death?Former or
usual residence.15

19 PLACE OF BIRTH OR REMOVAL

DATE OF BURIAL

1525 Eastern Ave. May 13, 1914

20 UNDERTAKER

ADDRESS

Pete Nicolaus 2046 Eastern Ave.

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

1525 Eastern Ave

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

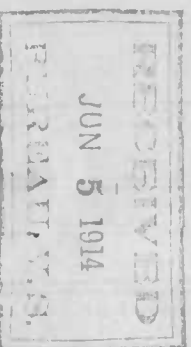
[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mining*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not faithfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Group"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcin-*

oma, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.*; *Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "As-thenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Hæmiplegia," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal *septicæmia*," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and qualify as ACCIDENTAL, suicidal, or homicidal, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.



WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS, should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH

4738

(120)

STATE OF MARYLAND
CERTIFICATE OF DEATHCounty Balto.Registration Dist. No. 41Village or City Highlandtown (No. 102, 512)

St.; Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME

Emma Yeager

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White5 SINGLE,
MARRIED,
WIDOWED,
OR DIVORCED
(Write the word)Married

6 DATE OF BIRTH

June 16, 1867
(Month) (Day) (Year)

7 AGE

46 yrs. 10 mos. 26 ds.If LESS than
1 day, hrs.
OR min. ?

8 OCCUPATION

(a) Trade, profession, or
particular kind of workHouse Wife(b) General nature of industry,
business, or establishment in
which employed (or employer)

9 BIRTHPLACE

(State or country)

Balto. Md.

PARENTS

10 NAME OF
FATHERJohn Batte11 BIRTHPLACE
OF FATHER
(State or country)Balto. Md.12 MAIDEN NAME
OF MOTHERMarion Irons13 BIRTHPLACE
OF MOTHER
(State or country)Balto. Md.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

George Yeager

(Address)

182 5 1/2 St.

15

Filed

May 12, 1914 W.E. McCloskey

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

May 11, 1914
(Month) (Day) (Year)

17

I HEREBY CERTIFY, That I attended deceased from

May 10, 1914, to May 11, 1914that I last saw her alive on May 10, 1914and that death occurred on the date stated above, at 12 m.

The CAUSE OF DEATH* was as follows:

Pericarditis(Duration) 6 yrs. 6 mos. 6 ds.Contributory
SecondaryChronic Bright's Disease(Duration) 4 yrs. 4 mos. 4 ds.

(Signed)

J. L. H. Nixon M. D.May 12, 1914 (Address) 248 So. Thut

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ____ yrs. ____ mos. ____ ds. In the State ____ yrs. ____ mos. ____ ds.

Where was disease contracted,
if not at place of death?Former or
usual residence.

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Oak Lawn Cemetery May 13, 1914

20 UNDERTAKER

ADDRESS

Lilly & Zeiler 4038 W. 1st St.

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mining*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcin-*

oma, Sarcoma, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and qualify as ACCIDENTAL, SUICIDE, or HOMICIDE, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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RECEIVED

JUN 5 1914

MAU. V. S.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH

4739

County

Balto

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registered No.

32

Village or City

Arlington

(No.

5239 St Charles Ave

Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME

No Name

Yeatman

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 SINGLE, MARRIED, WIDOWED, DIVORCED (Write the word)

6 DATE OF BIRTH

May 2, 1914

7 AGE

X yrs. X mos. X ds. If LESS than 1 day, hrs. a few min.?

8 OCCUPATION

(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE (State or country)

Balto Co.

PARENTS

10 NAME OF FATHER

Bertram Yeatman

11 BIRTHPLACE OF FATHER (State or country)

Balto Co.

12 MAIDEN NAME OF MOTHER

Theresa C. Sohr

13 BIRTHPLACE OF MOTHER (State or country)

Balto Co.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Father

(Address)

5239 St Charles Ave

15

Filed

5-3

1, 1914

Harry L. Taylor

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

May 2, 1914

17

I HEREBY CERTIFY, That I attended deceased from

5/1

1914, to

1914

that I last saw him alive on

1914

and that death occurred on the date stated above, at 12 m.

The CAUSE OF DEATH* was as follows:

Premature Birth

a few minutes (Duration) yrs. mos. ds.

Contributory (Secondary)

(Signed) Chas. S. Parkerson, M. D.

5/2, 1914 (Address) 3116 W. North

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, If not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

Salem Cemetery

DATE OF BURIAL

May 3rd, 1914

20 UNDERTAKER

Philip Devoe

ADDRESS

119 Q. Euter St

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

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[Approved by U. S. Census and American Public Health Association.]

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